103-02870/

Report
and
Recommendations

Québec
Commission d'étude sur
les services de santé et
les services sociaux

EMERGING
SOLUTIONS

This publication was produced by the Commission d'étude sur les services de santé et les services sociaux.

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Note:
In the following document, the masculine form applies to women as well as men, wherever applicable.

Legal deposit
Bibliothèque nationale du Québec, 2001
Bibliothèque nationale du Canada, 2001
ISBN 2-550-36960-2

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December 18, 2000

Madame Pauline Marois
Minister of State for Health and Social Services
Government of Québec

Dear Madam:

The members of the Commission d'étude sur les services de santé et les services sociaux are pleased to submit our report to you.

In line with the mandate that the Government of Québec conferred on us on June 15th, we hereby submit to you the recommendations and proposals that emerge from our work.

This report also presents the key facts derived from our consultations with the population, experts and organizations representing the network.

We thank you for the confidence that you have placed in us by entrusting us with this mandate.

Sincerely,

Michel Clair
Chairman

Léonard Aucoin
Commissioner

Howard Bergman
Commissioner

Rosette Côté
Commissioner

Pierre Ippersiel
Commissioner

John LeBoutillier
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FOREWORD

The Commission d'étude sur les services de santé et les services sociaux (Commission of study on health and social services) was created on June 15, 2000. It was given the mandate to hold a public discussion on the issues facing the health and social services system and to propose solutions for the future. To do this, it gathered the points of view of the population, health network partners, representative organizations and experts, mainly on the two themes relating to its mandate: the financing and organization of services.

This report contains two parts and an appendix. Part I, which is divided into 5 chapters, presents the recommendations and proposals of the Commission. Part II reports on the highlights of consultations carried out with citizens, experts and groups. The appendix contains the summaries of briefs presented by national groups.

Throughout their mandate, the Commission members sought to cover all the issues using an analytical grid with a broad scope. However, they are aware that, given the limited time and the choices made by the Commission, they were unable to give certain clienteles or themes the treatment they deserve.

The commissioners would like to thank everyone who participated in the consultations and hearings held throughout Québec, especially given the short time period in which they took place. The commissioners were impressed by the quality of the views and arguments put forward and the strong desire of all the players to help improve our health and social services. They would also like to thank the many collaborators who so enthusiastically responded to their requests.

INTRODUCTION

The challenges facing humanity today are innumerable. These often seem like insurmountable challenges in poor countries, and exciting challenges in developed countries.

Improvement of world health is one of these key challenges faced everywhere: in all countries, cities, rural areas and villages on the planet. Prevention, cure, care! Health for everyone! Without discrimination! This is both a utopia and an essential goal, a foundation of human solidarity.

For a long time, developed countries have been sheltered from the fatalism of epidemics and disease. The development of health sciences has been meteoric. The combined strength of knowledge and economic means has pushed back the boundaries of human vulnerability. Public authorities have progressed from public health initiatives to the deployment of highly elaborate health systems which, in all developed countries, have become the largest civil organization. Citizens are increasingly taking control of their health and want to live better, longer lives.

During the last 50 years, the vast majority of developed countries have established health and social services systems which are largely publicly funded. There remains one exception: the United States. Almost all other societies have chosen in one way or another to use government funding to insure against the risk of disease. The human values on which all these health care systems are based are the same everywhere: solidarity, equity and compassion. The profile of these systems may vary, but their foundations are the same.

UNIVERSAL CHALLENGES

The problems and challenges assailing the foundations of these systems are also similar everywhere. What is the purpose of the system? Is there a limit to the resources that society can invest in it? How should choices be made? How can the advantages for society and individuals be maximized with the money available? How can the underlying values of this entire societal structure be preserved?

There are numerous sources of all of these questions, but one emerges fairly clearly. It is at the junction of the lightening development of knowledge and the possiblity, which is limited, of offering everyone all of the means made available by science. A sort of impending rupture or confrontation can be seen in this: the supply of science is pushing the values of solidarity and equity to their limit.

In other words, the increase in the number of possible interventions, which are becoming more and more expensive, is coming up against the limits of society's willingness or capacity to finance them. The acceptance that the resources of any society have limits leads to the necessity to look for better results and thus to make choices at all levels of a health system.

To date, no society has found the perfect balance between the obligation to make choices and perform, on the one hand, and to ensure equitable access to all possible nealth services on the other. Everyone is trying to find a solution.

These challenges are not only fundamental, but also structural, organizational, managerial and financial in nature.

During the last 15 years, most developed countries have reviewed the governance of their systems, which have all been evolving rapidly. From Sweden to New Zealand, from Hungary to the United Kingdom, the organization of services has been called into question almost everywhere. And in this world-wide effort to adapt, everyone benefits from the experience of others.

The evolution of these enormous, changing complexes of services also poses unprecedented managerial challenges, from the lowest to the highest levels. Everywhere, both the level of funding and the sources and methods of allocating resources are being reviewed and adapted with the same concern for the consistency of health and welfare objectives for the population on the one hand, and the nation's global competitiveness on the other.

The challenge facing Québec is therefore not unique. It is specific to our context, but universal in its definition.

THE MANDATE OF THE COMMISSION

The mandate of the Commission focused on the organization and financing of health and social services. In this regard, we had to solicit national and international experts, consult with interest groups and hold public hearings, notably in the regions, and finally submit recommendations to the government.

We situated the reflection required by our mandate first in the Québec, and then in the Canadian and international contexts. We interpreted it essentially as an opportunity to suggest ways to protect, adapt and improve our system. All our considerations and debates, as well as the many proposals that we examined, had the same purpose, whether explicitly or implicitly: to ensure the sustainability and continuous adaptation of our system to contemporary realities, in the interest of each and every one of us. This is the purpose of our report.

We have done our best, given limited time and modest means, to go straight to the heart of the issues, putting aside taboos and ideology. We solicited and obtained the trust of everyone and also benefited from everyone's generosity. We listened, discussed and consulted with the aim of seeking, in the intelligence, openness and will of the players themselves, a vision for the future of our health and social services, one which could be supported by all Québeckers.

We hope that many people will identify with what we have outlined and proposed, emerging solutions that are as yet undeveloped but firmly rooted in Québec and part of a universal and contemporary analysis. We also hope that the people whom we met everywhere in Québec, those who hold the future in their hands and who so enlightened us, will now take up the torch with determination. They are the ones who will be able to pursue the development of a Québec model, one that is original and adapted to both regional and cultural particularities.

MAKING CHOICES AND PERFORMING

We would like to clearly express to all our fellow citizens the essential messages that inspired our work and underlie our report.

Québec has a highly developed health and social services system to which the vast majority of citizens are very attached and of which we deserve to be proud. However, this system is facing major problems, ones which it would be dangerous to underestimate or allow to persist. These problems are primarily organizational and concern both those who govern, managers, professionals and employees as well as users. Citizens must be clear-headed and sensitive in giving thought to the future of their system while remembering that all that is demanded of the system ultimately comes from them.

To ensure the sustainability of our system, it must first of all be accepted that, as in all other societies, the resources that Québec society can devote to health and social services are limited. This acceptance leads to two indisputable and inextricably linked obligations: the obligation to make choices and to perform.

No one can dispute the obligation to make choices. For a long time, political leaders, administrators, health professionals and citizens were all convinced that the solidarity underlying publicly funded systems freed us from having to make choices. But choices must be made. Leaders must make choices about the limits of financial resources and about medical technologies and insured drugs. Administrators and clinicians must also make choices or, if not, accept the choices made by others. Finally, each citizen must choose between solidarity, equity and the risk inherent in the philosophy of "everyone for himself."

One thing is clear: a laisser-faire approach and the absence of informed, structured and shared choices lead directly to arbitrary access to services and the collapse of the very foundations of the system, that is, of the values of solidarity and equity. It is not a coincidence that in June 2000, the World Health Organisation chose to use the word "rationing" to describe this responsibility of national governments of all countries to "ensure that limited resources are spent in identified high priority areas."[1]

The obligation to perform is just as demanding and no less essential. Performance is not an accounting exercise. Rather it means that, with limited resources, solidarity and equity are only meaningful if we accomplish the maximum with the money available.

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[1] **World Health Organisation, *The World Health Report 2000, Health Systems: Improving Performance*, Geneva, 2000, p. 58.**

Thus, the organization of services must be designed to implement the above-mentioned choices efficiently and effectively. Performance also implies the obligation to measure the results obtained, on the basis of reliable clinical as well as administrative and financial indicators. To do this, it is necessary to have appropriate information systems, but especially a culture of excellence that does not shy away from, but rather seeks comparisons with, the Canadian and international levels.

EMERGING SOLUTIONS

We propose that these two obligations – to make choices and to perform – be met with a new vision for the future rather than with nostalgia about old paradigms. We propose that all the players engage in a sort of "big bang" of ideas and ways of looking at things, one that will allow us to take off our blinders and get out of the far too numerous ruts that have developed over the years.

We know that it will require several years of effort to gradually implement the vision being proposed. To this end, we propose a strategy of relying on teams who already advocate this new approach and who are most willing and ready to implement it. Thus, in putting this new perspective into action, a balance must be maintained constantly between the desire to make progress and the concern not to rush anyone needlessly. This will require a continuity and stability both in orientations and among leaders.

The Commission's major proposals concern the organization of services. We wanted to go beyond clichés (e.g., "the citizen is at the centre of the system," "money follows the patient," "breaking down 'silos'") and propose concrete models for the reorganization of services, more particularly primary care medical and social services, as well as challenges for specialized services for youth and for hospitals at all levels. These models draw on the best initiatives and proposals from here but are also in line with the best of international practices.

We are profoundly convinced that these emerging solutions are preferable to the status quo. Among the many solutions that emerged from our consultations are: the Family Medicine Groups; networks of integrated services, for example, for seniors who have lost their autonomy; homogeneous services in all CLSCs, particularly for youth; and local, regional and supraregional hospitals with clear mandates, linked to each other through service "corridors" and a new hierarchical configuration of medical services.

PROACTIVE MANAGEMENT

A new leitmotiv must be quickly adopted by the entire network: **decide, act, evaluate and adjust**. This is what will make the difference between a network that is going around in circles, with rare pilot projects which are eventually forgotten, and a network that gradually implements a new organization of services.

We sincerely hope that the spirit, as much as the content of our proposals, which recognizes the importance of competent, motivated and valued human resources whose full potential is put to use in work over which they have more control, will go beyond the stage of noble intentions. This is valid for everyone: support staff, nurses, physicians, social workers and other professionals. What is observed is that the culture of the status quo merely allows the irritants in the current way of operating to persist.

We believe that management is an essential function which has for too long been devalued in the operation of health and social services. Strong doses of management need to be reinjected into the system. No organization can survive and develop without competent leaders who are motivated by the achievement of results and who have sufficient room to manœuvre.

FINANCING

The financing of our system is a fundamental challenge because of the vulnerability of its fiscal base in a world of fierce competition, one in which Québec does not dictate the rules. Nevertheless, we will continue to rely on taxation as the main source of public funding of our services. This will require a high level of discipline on the part of all players and an openness to other forms of risk mutualization to avoid what must be considered as predictable offloading operations in the event of economic difficulties or social improvidence.

The choice of insured services, the allocation of resources to the regions and institutions, and systems of remuneration and payment of the players will be the key elements in replacing old budgeting methods without measurable goals by effective management that can meet real needs. If our resource allocation methods are not consistent with the goals sought, billions of additional dollars could be injected into the system without ever achieving these goals.

The Commission is putting forward a comprehensive and daring strategy to support the financing of priority needs and the adaptation of the network to high standards of performance and quality.

We know that significant financial efforts will be required from both citizens and governments to support the triple transition -- demographic, epidemiological and technological -- over the next few years. We therefore believe that the Government of Canada must reconsider its participation in the financing of this transition and be open to adopting a modern interpretation of the five principles contained in the *Canada Health Act*.

GOVERNANCE

We propose a "quiet revolution" in the governance of the network, first of all, by clarifying roles and then by specifying the hierarchy of accountability of a system composed of three levels of responsibility. We recommend that a distinction be made between the essentially political functions, such as establishing orientations, determining goals and evaluating results, and the functions of operational management. Our vision is based on the belief that it is essential that governance be both visionary and organized at all levels. A population-based approach, renewed emphasis on management and bringing decision-making closer to the populations affected by it are all underlying principles of our recommendations regarding governance.

Finally, the Commission proposes that Québec's political, social and economic leaders consider what the best means are to meet, within 10 years, the challenges created by the delicate, fundamental political decisions that will have to be made and by the overall administration of Québec's largest organization. We therefore propose that they consider which operational structure would provide the best administration of the some 200 billion dollars that Québeckers will spend on health and social services during the next 10 years. This investment is equivalent to 14 times the investment made in James Bay. Surely it merits attention.

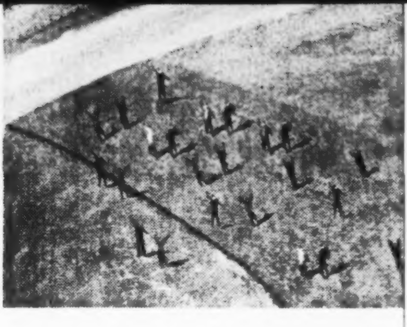
CHOOSING A PROJECT

In short, we are faced with a collective choice. Leaders, citizens and service providers can cling to the same old ways of thinking and seeing things and live in the nostalgia of an obsolete status quo, in which reality will be a series of foreseeable crises. Or we can opt for another view of the organization and financing of our system. Collectively, we can give ourselves a new vision, adopt the means for it to develop, and re-appropriate the evolution of our system. This project will be demanding for political leaders, managers, professionals and unionized employees as well as for all citizens.

But such a choice would give us a project for the future of our system. And such a project would return a sense of pride and satisfaction to those for whom the services exist as well as to those who provide these services. It would restore the meaning of social solidarity and work well done.

PART I

ANALYSIS AND RECOMMENDATIONS



PART I

1

A VISION FOR THE NEXT DECADE

In the eyes of the Commission, Québec's concerns about its health system are echoed in the analytical framework used by the World Health Organisation (WHO) in its *World Health Report 2000–Health Systems: Improving Performance*.[2] In proposing a vision for the next decade, the Commission has drawn upon this analytical framework. The experts whom we met stressed that, as applied to a modern system like the one we want Québec to have, WHO's framework proposes a highly appropriate perspective for a process like ours. Indeed, the Institut national de santé publique du Québec (Québec national institute of public health) suggested it to us.

WHO's framework is built upon a number of different elements. First of all, WHO defines a health system as "*all the activities whose primary purpose is to promote, restore or maintain health*." This definition encompasses services to individuals, public programs aimed at prevention, and social policies aimed at improving health and welfare. This conception was widely endorsed by the groups from whom we heard during the regional consultations and the national hearings.

In line with the wishes of the majority of the groups and experts we met, WHO's framework also recognizes the central responsibility of the state for the health and welfare of the population. In this model, the government is responsible for the performance of the system as a whole; the government must guide the system, particularly as regards the conduct of intersectoral actions, and it must ensure the viability of the system. It is up to the government to define the system's overall parameters and to determine its level of funding, in line with its political and social choices as well as with the values and expectations of the population.

WHO's framework is also consistent with many of the comments heard by the Commission about the objectives of the system. From WHO's perspective, any health system must in fact seek to achieve three main objectives:

Health: to improve the overall health and welfare of individuals and of the population, as well as to reduce disparities in health and welfare between the groups that make up the society.

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[2] World Health Organisation, *World Health Report 2000 – Health Systems: Improving Performance*, Geneva, 2000.

Responsiveness: to respond to the legitimate expectations of individuals and groups, without discrimination. This is expressed by the respect for persons and of their right to dignity, confidentiality, and information, as well as by the attention to individuals, including in particular the speed of case management, reasonable waiting times, the quality of the environment, and the possibility of choosing one's own care provider.

Fairness in financing: to ensure financial protection against the costs of ill health and to distribute the financial burden and the sharing of risks in an equitable fashion.

Focus on performance

WHO's approach underlines the importance of linking the debate on the level of funding to the attainment of the overall goals of health and welfare, responsiveness and fairness in the distribution of the financial burden. In this analytical model, the system's performance is measured by the relationship between the attainment of these key objectives and the resources invested: for a given level of resources, the health system is performing better to the degree that its objectives are more fully attained. The major concern of those who lead and manage the system is to improve its performance, that is, to obtain better results given the available resources.

According to WHO, the performance of a health system depends on how well it carries out four vital functions:

- service provision
- creating resources
- financing
- stewardship.

As regards the **provision of services**, the choice and organization of services are crucial. Because resources are limited, they must be allocated to those interventions that correspond to established priorities and that are recognized as effective and financially viable. As for the organization of services, WHO favours the flexible integration of service providers through contractual agreements rather than through hierarchical, bureaucratic and centralized structures or unregulated markets. The use of long-term contracts offers more flexibility and better possibilities for innovation, while at the same time allowing for overall control over strategic objectives and for the financial protection of individuals.

The exchange of secure information through the use of modern communication techniques encourages integration and ensures that the autonomy of care providers and confidentiality are respected.

According to WHO, all health systems are characterized by a **wide range of resources**, which must be adequately managed: human resources, sometimes highly specialized and requiring lengthy training; physical facilities; equipment; supplies; drugs; information; and knowledge. It is important to ensure that these resources are of high quality and to maintain a healthy balance between recurrent and capital spending. Good performance requires that the mix of these various types of resources is well planned and balanced according to changing needs, public expectations, and available technology. Examples include the geographic distribution of doctors, the balance between the number of family physicians and specialists, and the distribution of fields of practice between the various health and social services professions.

With respect to **financing**, WHO considers it essential to provide for a high level of prepayment of high-priority insured services, either through public funding from income taxes and other taxes, or through compulsory insurance with contributions and premiums. This is the best way to guarantee fairness and protection against the financial risks associated with illness. WHO recommends avoiding the fragmentation of funding and it suggests the introduction of payment mechanisms for institutions and professionals that will serve as an incentive to improve the quality of services and the responsiveness of the system. It suggests that purchasing strategies consistent with the objectives of the system be explored. Such strategies would make it possible to seek the best available interventions and to create a form of competition among providers within a system funded and controlled by the government. Finally, according to WHO, the level of funding is not an objective of the health system, because the setting of the level and sources of funding is a social and political choice.

To improve the performance of a health system, **good stewardship** is indispensable. For WHO, the government is responsible for this stewardship. The government establishes an overall vision and defines the role of the principal actors within the system. The government works on the basis of a realistic scenario that takes account of resources and that seeks to attain the objectives that have been set. It has at its disposal an information system that includes performance indicators of the key functions and of the achievement of objectives. It has the capacity to identify the overall problems of the system at any moment and to evaluate alternative solutions. Its influence is exercised through regulation and awareness strategies that are consonant with the objectives of the system, and it applies these strategies in a financially sound way. Taking into account the interests of the whole population, the government defines the role of the system and involves the private and non-profit sectors in achieving the objectives. Finally, as Gro Harlem Brundtland, the Director-General of WHO, stresses in her introductory message: *"Stewardship is ultimately concerned with oversight of the entire system, avoiding myopia, tunnel vision and the turning of a blind eye to a system's failings."*

MAKING CHOICES: A NECESSITY

Increasingly sophisticated technologies, including both equipment and drugs, are now available for diagnosing and treating illnesses. These technologies generally make it possible to make better diagnoses, to provide more adequate treatment, to prolong life and to improve its quality, and, in some cases, to save money. As soon as these technologies become available, health professionals and the public want access to them. However, not all of these technologies and developments are equally effective. Some are very expensive, not only to purchase but also to operate.

A recent study by the Conseil d'évaluation des technologies de la santé du Québec (Québec council for the evaluation of health technologies – CETS) provides a striking illustration of the pressures created by expensive new technologies.[3] *Left Ventricular Assist Devices* (LVADs) are miniature pumps implanted in certain patients suffering from cardiac insufficiency to increase their chances of survival while waiting for a heart transplant. According to CETS, the cost of a cardiac transplant is around $200,000 if account is taken of the cost of the device and its installation and of the fact that 30% of patients who receive an LVAD do not survive to transplantation. Each year, around 1,500 patients in Québec could benefit from this new technology. Therefore, if the implantation of LVADs became the norm, it would cost half a billion dollars per year.

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[3] Conseil d'évaluation des technologies de la santé du Québec (2000), "Implantable Ventricular Assist Devices: Should They Be Used in Quebec?" Case taken from the brief presented by the Institut national de santé publique du Québec. CETS recently became the Agence d'évaluation des technologies et des modes d'intervention en santé (AETMIS).

At the time of CETS' study, at least three patients had received LVADs, although no formal decision had been made about whether to include this intervention on the list of insured services. The technologies are available, the medical indications are clear, yet there is no directive that specifies whether the service is insured or not. What is certain, however, is that the general use of LVADs would have a major impact on health spending, and the resources devoted to it would be unavailable for interventions that may be more effective and that would affect a larger number of people. For example, according to the brief of the Institut national de la santé publique du Québec, CETS estimates that, depending on the particular application, the LVAD technique costs between $50,000 and $186,000 to add one year of life. In comparison, the cost-effectiveness of screening tests for breast cancer has been estimated at around $5,000 per life year. In a context of limited financial resources, this kind of situation makes for ethically difficult choices.

For WHO, it therefore becomes important to recognize that all systems have to ration: *"No health system can meet all … needs, even in rich countries. So either there must be conscious choices of what services should have priority, or the services actually delivered may bear little relation to any reasonable criterion of what is most important."*[4] In other words, establishing priorities becomes unavoidable: if services have to be provided to everyone, all of the services cannot be provided. The government therefore has the responsibility to institute decision-making mechanisms that will allow such choices to be made.

In this spirit, a *new universalism* needs to be promoted according to WHO: all those in need should receive high quality essential care according to criteria of effectiveness, cost and social acceptability. A priority ranking of interventions must be established in line with the following ethical principle: although it may be necessary and effective to ration services, it is unacceptable to exclude whole groups of the population.

The proposed approach does not in any way amount to a technical "de-insuring" of services that is aimed only at reducing costs. Instead, the proposal is to define, on the basis of "social" priorities, the services that need to be provided to meet one objective: to optimize the impact on the health of the population, taking into account not only clinical indications and available resources but also equity objectives, ethical aspects, and the other priorities that society chooses.

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[4] World Health Organisation, *World Health Report 2000 – Health Systems: Improving Performance*, Geneva, 2000, p. 52.

Bearing in mind that public demand is generally more focused on clinical interventions than on preventive activities, one of the principal tasks facing those who must choose priority services is to achieve a balance between public health activities aimed at the whole population and clinical activities provided to individuals.

1.1 THE GOALS OF THE SYSTEM: PREVENT, CARE, CURE

Québeckers generally regard health as both an individual and collective asset. Because they hold this value, they tend to see health spending as an investment that contributes as much to personal welfare as to collective development and to social prosperity. They are also solidly in favour of ensuring that the financial burden of this investment is equitably shared.

This conviction, heard repeatedly during the regional and Québec-wide hearings, clearly shows that the responsibility for health and welfare is shared by the state and individuals. It also aptly summarizes the double raison-d'être of the health and social services system: first, to permit each person, and the population as a whole, to develop and to enjoy good health for as long as possible; and, second, to assume collectively the risks of illness, accidents and psychosocial problems that each citizen faces throughout his life.

1.1.1 AN INVESTMENT IN HEALTH

The link between health and living conditions is well established. We now know that it is possible, indeed necessary, to act collectively on the major determinants of health, particularly lifestyles, education, employment, income, and the environment. It is the state's responsibility to initiate strategies aimed at prevention and health protection and promotion and to create the conditions that will assist individuals and groups to develop the ability to take care of themselves.

In this area, public prevention interventions, as well as preventive practices integrated into clinical practice are often effective and financially sensible. Thus, interventions against infectious, environmental, and occupational risks, as well as interventions aimed at modifying lifestyles or living conditions that are harmful to health, can contribute directly to the improvement of health status of individuals and groups, and to reducing the health inequalities that are still evident among the Québec population.

Because we are convinced of the need to foster an improvement in the health-potential of the population, the Commission considers that it is necessary to design appropriate modes of organization and financing in order to better integrate activities of prevention and health promotion as a priority among the range of services provided by the state.

1.1.2 PROTECTION AGAINST ILLNESS

Although they recognize that prevention must play a larger role, most Québeckers want above all to be assured that they and their families will receive the best possible care and services in the event of illness, accidents or psychosocial problems.

For historical reasons, our system has in the past emphasized "medically required" and "hospital-dispensed" services. With the arrival of the new technologies and new clinical approaches that have led to the development of ambulatory services and social integration, many of the responsibilities that used to be assumed by hospitals and treatment centres are now being transferred to other institutions, to families, to the community, and to community agencies. These changes are very recent and there are still too few mechanisms and resources to support the persons and groups who take on these responsibilities. Sometimes, therefore, the very organization of the health and social services system is a source of inequality, because the services that used to be insured when hospitals and treatment centres dispensed them are no longer insured when they are provided by the community or the family.

It must also be recognized that the notion of "medically required" services, which still serves as the basis for the financing of the Canadian health system, offers little to meet the needs of persons and groups experiencing social problems like family violence, addiction, homelessness, and social isolation. Nevertheless, we know that these problems often have a dramatic impact on the physical and mental health of those who are experiencing them. What can be done in the future so that the services that are clearly "socially necessary" and high-priority are given the attention and resources that they deserve in a model founded on the notion of "medically required" services?

Added to this question is another issue of growing concern -- diagnostic or treatment services that are "technologically required." It is obvious that the technological breakthroughs of recent years are helping to save or prolong lives and to improve the quality of life. Every year, technological advances, like new drugs, also offer new diagnostic or intervention possibilities that raise the hopes of many people. Given extensive media coverage, these innovations come to be perceived as health services that are currently being provided. The calls and pressures to have them included in the basket of insured services are enormous.

A growing number of citizens, well aware of their state of health, also now want to make their own decisions concerning their health and welfare. They want to have access to relevant and high-quality information so as to make informed choices and to receive services that match their values and expectations.

In consumer societies like ours, it is also the case that health services are frequently perceived as "commodities," that is, as one type of consumer good among others. When a service is seen as useful and is available, many people believe that they should have immediate access to it, even if that means paying the costs themselves.

In sum, more and more citizens want to make their own decisions about issues affecting their health. They want the best service, at the right time, for the best price.

1.1.3 PREVENT, CURE, CARE

In the opinion of the Commission, adapting the health and social services system implies identifying, for the whole population, appropriate objectives established on the basis of the health status of the population. Applying this approach (see Diagram 1), the Québec population, like any other, can be divided into three large groups[5]: those who see themselves as being in very good or excellent health; those who consider themselves to be in good health; and those who see their health as average or poor.

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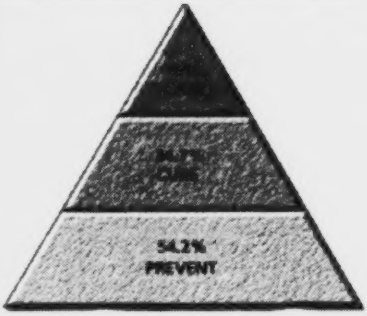
[5] 1999 Annual Report on the Health of the Montreal Population. *Prevent, Cure, Care: Challenges of an Ageing Society*, Direction de la santé publique, Régie régionale de la santé et des services sociaux de Montréal-Centre, Montréal, 1999.

DIAGRAM 1 Priority Intervention Objective by People's Perceived Health Status



Source: 1999 Annual Report on the Health of the Montreal Population. *Prevent, Cure, Care: Challenges of an Ageing Society*, Direction de la santé publique, Régie régionale de la santé et des services sociaux de Montréal-Centre, Montréal, 1999.

In the first group, comprising more than half the population, the primary objective is "**prevention**," that is, to preserve and, if possible, to increase the "health potential" of persons who belong to this group. It is well recognized that, at present, there are not enough systematic preventive actions targeted at this group, and that Québec's efforts as regards health determinants are less intensive than those undertaken in other developed societies.

The second group, which represents a little more than one-third of the population, includes those people who have acute but reversible problems, chronic problems, risk factors or other health problems for which there are effective treatments. With regard to this group, the top priority is to "**cure**," that is, to initiate appropriate cures in order to control the risk factors and, where applicable, to intervene at an early stage in the illness in order to prevent it from progressing and to reduce the risk of complications. In these cases, behavioural changes and the optimal use of curative treatments are the principal strategies. Psychosocial or physical rehabilitation methods are also very useful since they make it possible for the person to recover, in whole or in part, their autonomy.

In the third group, which represents 11% of the population, "**care**" is the most important objective. The persons belonging to this group suffer from a deteriorated state of health, accompanied by a deficit or a disability that is generally irreversible. In these situations, therapeutic approaches are not aimed at eliminating the problem but instead at improving the person's ability to adjust to the problem, to live a satisfying life despite the problem. The services required to provide care rely on generally low-tech interventions: in these cases, the quality of the relationship between the caregiver and the person receiving the care is of primary importance.

Although this schematic presentation should not make us forget that all three groups receive services aimed at prevention, curing and care, the model has the advantage of clarifying which objectives should be given priority according to health status. It also makes it clear that a balance has to be sought between prevention, curing and care.

In Québec and elsewhere, experience shows that such a balance is difficult to achieve. Thus, when pressure mounts to intensify the activities aimed at curing and care, preventive activities are often reduced. Moreover, what is the appropriate balance among interventions aimed at curing? Make less use of those technologies that are useful to some people who need them, or over-use curative interventions for persons suffering from irreversible or incurable conditions? These two decisions are key issues for clinicians as well as for managers. Lastly, what is the adequate response to the objective of care? The decades-old institutional approach favoured in Québec until quite recently has held up the establishment of community resources closer to the living environment of persons who have lost their autonomy. Much therefore remains to be done in the field of home care and services in order to promote the best practices for taking charge of persons whose health has seriously deteriorated or who are in the last stages of life.

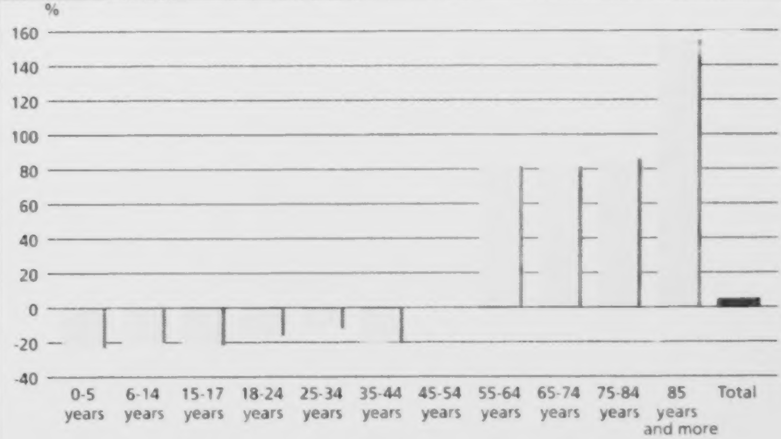
1.2 FACING THE CHALLENGES: MANAGING THE TRANSITIONS

The health and social services sector will be confronted by some major challenges over the coming decade. In the opinion of the Commission, adopting a preventive management approach is the only way to manage the sociodemographic, epidemiological and technological transitions that are now underway.

1.2.1 THE SOCIODEMOGRAPHIC TRANSITION

The first challenge facing the health and social services system is the rapid change in the composition of the population. From 1996 to 2021, it is forecast that the number of persons aged 0-14 years will decline by 20%, the number aged 15-64 years will be stable, whereas the number of those aged 65 years and older will increase by 92%. Were it not for this phenomenon, the population of Québec would have already begun to decline. Closer examination reveals that the population of those aged 65-74 years will increase by slightly more than 80%, compared to around 90% for those aged 75-84 years and more than 150% for those aged 85 years and older[6] (see Figure 1).

FIGURE 1 Population Growth, By Age, Québec, 1996-2021



Source: *Évolution des besoins de la population et implications pour le système de santé*. Présentation de la Conférence des régies régionales de la santé et des services sociaux du Québec–Santé publique, September 2000.

This demographic change will in all likelihood have a substantial impact both on social values and on the organization and delivery of services. This is especially true of hospital services. Analysis of the current consumption profiles of those aged 65-74 years and 75-84 years demonstrates that these groups are over-represented as regards the rate of hospitalization days for short-term physical care.[7]

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[6] Institut de la statistique du Québec, *Perspectives démographiques des régions administratives et des MRC 1996-2021*, Québec, 2000.

[7] D. Roy, R. Choinière and D. Lessard, *Évolution des besoins de la population et implications pour le système de santé*. Présentation de la Conférence des régies régionales de la santé et des services sociaux du Québec–Santé publique, September 1, 2000.

In social and economic terms, there is every indication that social inequality and poverty, which directly affect female heads of single-parent families and their children, will persist and will continue to exercise a strong influence on the demand for services. The changing nature of family and community dynamics will confront the health network with new situations for which equally new solutions will have to be found.

Facing up to the sociodemographic transition will require great flexibility on the part of the health and social services system and its partners, particularly at the level of the local and regional authorities who will have to identify the changing needs of the population. This will require improvements in the ability of the system to recognize and tap into the emerging needs of individuals and groups just as much as improvements in its ability to respond to those needs.

1.2.2 THE EPIDEMIOLOGICAL TRANSITION

Until the mid-1940s, infectious diseases were the preponderant health problem in Québec. Then Québec entered a period during which vascular illnesses, traumas, and respiratory illnesses became the most important scourges, with cancer gradually growing in importance and AIDS appearing at the beginning of the 1980s. Today, the various forms of cancer, diabetes, and disease of the joints constitute important causes of morbidity and mortality. In addition, problems of violence, suicide, and adjustment disorders, often linked to stress, are on the rise, as are mental disorders.

There is every indication that this epidemiological transition will continue at least until 2020, at which point the health problems of a statistically ageing population will be added, particularly cognitive disorders, neurodegenerative diseases and the accumulation, among frail older persons, of a range of concomitant health problems, as well as problems related to the loss of autonomy and to disability.

In fact, there is already a sharp rise in the prevalence and number of persons suffering from disabilities in Québec.[8] This marked increase is attributable in particular to the increase in life expectancy. However, survival years without disability do not seem to be increasing at the same rate. Because disability is a factor that is strongly associated with the use of health services, it is obvious that this trend is likely to have a major impact on the health and social services system. Data on health determinants are just as worrying. It is well known that tobacco use is higher in Québec than in any other Canadian province (see Figure 2). In fact, tobacco use alone explains a large part of the increased burden of disability observed in Québec over the last decade.

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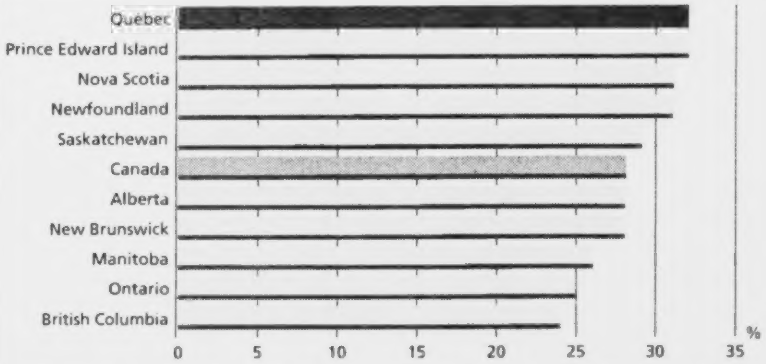
[8] From 1987 to 1998, the number of persons with a disability grew from 550,000 to 750,000 in Québec, i.e., a rise of 40% in a decade. Source: D. Roy, R. Choinière and D. Lessard, *Évolution des besoins de la population et implications pour le système de santé*. Présentation de la Conférence des régies régionales de la santé et des services sociaux du Québec–Santé publique, September 1, 2000.

FIGURE 2 Proportion of Current Smokers, by Province, Canada, 1996-1997

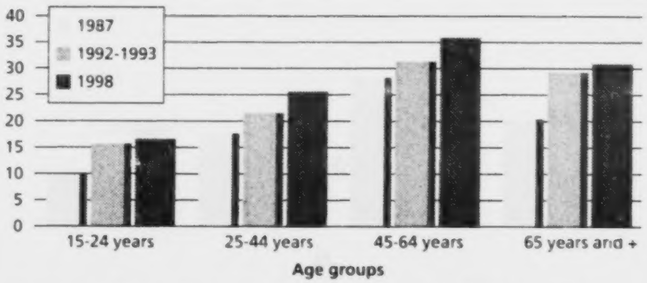


Source: *Évolution des besoins de la population et implications pour le système de santé*. Présentation de la Conférence des régies régionales de la santé et des services sociaux du Québec–Santé publique, September 1, 2000.

Another troubling fact is the growing number of overweight persons. With more than 35% of the population aged 45-64 years being overweight, we can expect a significant rise in chronic health problems associated with obesity, especially diabetes and heart problems. Figure 3 shows the growth in the proportion of the population that is overweight between 1987 and 1998. This trend is all the more troubling because the Québec population is, on the whole, sedentary.

From the psychosocial angle, changes related to lifestyles and family structure could have an impact on the social support structures on which Québeckers rely. On the basis of the trends observed over recent years, it can be predicted that more and more people will be living alone, which could increase the need of health-system workers for additional assistance.

FIGURE 3 Proportion of Overweight Persons in the Population, By Age, Québec, 1987, 1992-1993, and 1998



Source: Évolution des besoins de la population et implications pour le système de santé. Présentation de la Conférence des régies régionales de la santé et des services sociaux du Québec-Santé publique, September 1, 2000.

Although it is difficult to quantify, stress resulting from the difficulties of adapting to new modes of organizing social life and from new modes of work raises other issues. Disorders linked to stress and to mental health have become the leading cause of absenteeism for reasons of illness.

In addition, environmental changes, like the risk of deteriorating air quality, could affect cities of a certain size. An ageing population will be more vulnerable to the changes that can be foreseen. In addition, their housing needs will also have to be considered, as will the critical role of the living environment, which determines the capacity of the elderly to remain autonomous and maintain an active lifestyle and which, in fact, plays an essential role in reducing disabilities.

Biological stressors and the transmissible diseases that they cause, even though no longer representing as large a cause of mortality as they once did, can be expected to continue to exercise considerable influence. This is the case, for example, for Hepatitis C, the incidence and social costs of which had been largely underestimated until quite recently, as well as for AIDS, which is increasingly becoming a chronic illness thanks to new therapies. It is also likely that the phenomenon of bacterial strains that are resistant to antibiotics will continue and even increase. Fortunately, however, new vaccine preparations should make it possible to immunize vulnerable groups.

Meeting the challenge of the epidemiological transition will therefore require the adoption of clear objectives to overcome the principal social and health problems. Specific programs, based on the most recent knowledge and drawing on all available expertise, seem therefore to be the best means to face these challenges.

1.2.3 THE TECHNOLOGICAL TRANSITION

Technological breakthroughs, including the development of new drugs, undoubtedly offer potentially positive benefits for health. At the same time, however, this explosion of technology risks compromising the ability of the state to pay for its costs. Indeed, the combined effect of changing needs and the growth of diagnostic and therapeutic possibilities is already having an impact on the financial health of the health and social services system.

Available data confirms a constant increase in the consumption of drugs by all age groups between 25 and 100 years of age. This more frequent use of medication explains a sizeable part of the increase in costs recorded for drugs, which is running at around 15% per annum. In some cases, a new drug provides real health benefits; in others, the benefits are not significant. Solid cost-benefit analyses will have to be conducted before including new products on the list of insured drugs, and this will lead to important developments in the field of pharmacoeconomics over the next ten years.

Technological breakthroughs also affect diagnostic equipment, particularly the techniques of medical imaging. In Québec, the Agence d'évaluation des technologies et des modes d'intervention en santé (AETMIS – agency for the evaluation of health technologies and intervention methods), is responsible for, among other things, studying new technologies and making recommendations about their relevance and effectiveness. Better overall planning would also considerably improve the impact of decisions and investments relative to the inventory of technologies.

Moreover, information and telecommunications technologies are developing at an accelerated rate and are fundamentally transforming how organizations work. These technologies give health professionals the ability, in real time and at a distance, to exchange clinical information and to have access to new knowledge. They make it possible to improve the evaluation of services by linking clinical, financial and operational data. These also include modern decision-support tools, for both clinical and managerial use. These technologies increase the potential to improve the productivity of our organizations, but they require major investments in infrastructure and application.

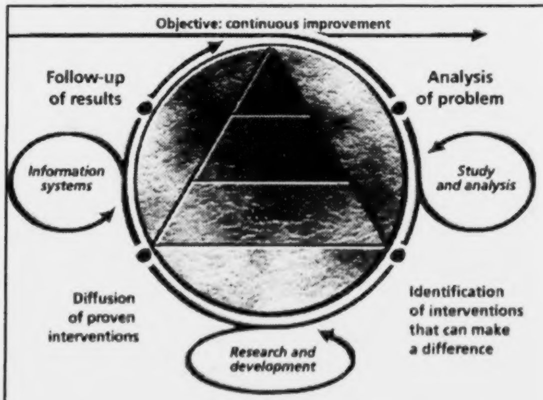
In a context of limited resources, the health and social services system therefore finds itself confronted, on the one side, by a strong demand for ever more costly technologies, and, on the other side, by growing needs for non-curative services, including interventions on health determinants, social services, residential care and home care. Dealing with the technological transition will require making choices. These choices should not only seek to maximize the effect of interventions on the health of individuals and the population as a whole, but should also contribute to the attainment of the health and equity objectives of the system.

1.3 PREVENTIVE MANAGEMENT

The challenges created by the sociodemographic, epidemiological and technological transitions in Québec are major. They require an analysis of problems and their causes, an evaluation of the issues and risks, choices between possible solutions—thus, to make decisions, to act, to evaluate the results, and to make the necessary adjustments to those actions. These are management responsibilities. Our health and social services system should create a common management vision, one that will be shared by professionals, managers, and the state in its capacity as funder and insurer. Everyone has to make choices, to make daily decisions that are as much political and clinical as they are managerial. In our field, these decisions are sometimes complex and uncertain. Decision makers need decision-making support tools designed to meet their particular needs. The role of managers is to provide this framework and these tools to make the best possible choices.

The Commission proposes a management approach structured around the major objectives of *prevention, curing and care*. This preventive management approach is inspired by the classic management cycle, illustrated in Diagram 2.

DIAGRAM 2 Objective: continuous improvement


Objective: continuous improvement
Follow-up of results
Analysis of problem
Information systems
Study and analysis
Diffusion of proven interventions
Identification of interventions that can make a difference
Research and development

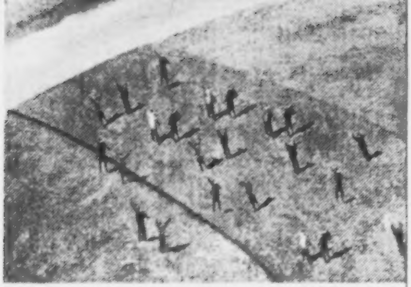
Source: 1999 Annual Report on the Health of the Montreal Population. *Prevent, Cure, Care: Challenges of an Ageing Society*, Direction de la santé publique, Régie régionale de la santé et des services sociaux de Montréal-Centre, Montréal, 1999.

Centred on health and social services objectives, this approach is rooted in a logic of continuous improvement. It proceeds sequentially: the analysis of problems and their causes; the identification of possible interventions; the deployment of effective interventions; and the systematic monitoring of the results of those interventions. The approach applies at each level of the system – the local, regional and province-wide levels – as well as to the relationship between health professionals and the persons who consult them.

At each stage, this approach depends on information management and on reliable data. For clinical decisions, this information will be the case histories and the examinations necessary to make an accurate diagnosis, the choice of the therapeutic intervention based on the results of research or experience, and an appropriate clinical follow-up. For administrative decisions, it will be necessary to conduct studies and analyses and to develop information systems and indicators. As regards public policy choices, information on the cost-benefits relationships will be cross-tabulated with other policy choices and weighed in the light of the values and orientation on major social issues.

Preventive management is based on an "anticipative" and proactive management approach, which promotes decision making based on the best knowledge in a perspective of effectiveness for the largest number, at the best possible cost, and protecting the continuity of other social investments that are essential to social development. It seeks, in short, to develop and preserve the potential health and welfare of persons and communities.

As we will see later on, the Commission's recommendations are directly inspired by this preventive management approach. The future of our health and social services system depends on the choices that we make today. In our view, there is no doubt that the adoption of this model, at all levels of decision making in the network, can contribute to improving the overall performance of the system and help it cope with the major transitions that will confront it.



PART I/2

ORGANIZATION OF SERVICES: IT'S TIME FOR ACTION

2.1 FINDINGS

2.1.1 A COMPLEX, DIVERSIFIED AND CONSTANTLY CHANGING REALITY

The organization of health services and social services is a reality that is complex, diversified and constantly changing. This reality produces the same challenges for all industrialized countries, as was shown in the expert forums organized by the Commission.

Health services

The development of new technologies and new drugs, the acquisition of new knowledge and the specialization in professions have made it possible to "cure" individuals affected by acute diseases more rapidly and to better "care" for individuals suffering from chronic diseases.

Nowadays, hospital stays are shorter for some surgical procedures. However, several chronic diseases are on the rise, for example, cancer, heart failure, lung disease, Alzheimer's disease, loss of autonomy in the elderly, and serious and persistent mental disorders. They require greater intensity and diversity of medical and social services, and necessitate continuous follow up and the complementary expertise of numerous professionals, institutions and community organizations.

This way of delivering services calls for greater participation from the patient himself, his family and community. Although we are living longer and in better health than before, we are also living longer with our disabilities. We also remain in the community for as long as possible. This is what the population wants, provided that the services required and resources needed are available.

Lastly, the links between the health of individuals and their behaviours, socio-economic conditions and certain environmental factors are being increasingly documented. Hence, the importance of individual and collective measures of health promotion and protection, and disease and injury prevention that are better targeted and integrated.

Social services

Social problems, which are becoming increasingly important to the population, are growing in number and severity. Examples are psychological distress and suicide among young people, problems of mental health, drug addiction and alcoholism, social isolation of seniors, family violence, and homelessness. Moreover, poverty has its dramatic effects on health. We need only recall the following facts presented by the directors of public health:

- The link between poverty, a low level of education, and poor health is well known.
- The population in underprivileged neighbourhoods live an average of 10 years less than the population in privileged neighbourhoods in the Montréal-Centre region, compared with 6 years for Québec as a whole.
- Single parent women and their children have become poorer.[9]
- The new face of poverty is often unemployment, precarious employment and sole parenting.
- Pregnant adolescents are increasingly younger and often come from underprivileged environments.

It should, however, be noted that the income of single individuals and the elderly have markedly increased.

2.1.2 MAJOR PROBLEMS OF ACCESS, CONTINUITY AND COORDINATION

Lack of access and continuity for citizens

It is hard for a citizen to find a family physician who will agree to take him as a patient. He does not know exactly what health care services and social services are provided by the local community service centre (CLSC). Whenever he has a health problem, he tries to make an appointment to see a doctor. He either goes to a walk-in clinic to see a general practitioner or a specialist, or to the hospital where he knows that the emergency room (ER) is open round the clock, seven days a week, and that there are always doctors there. He often will have to wait several hours before seeing one. He will most likely have problems accessing laboratory diagnostic tests and especially medical imaging. If he does not have to be hospitalized urgently, his name will go on one of the many waiting lists. If he has to be hospitalized straight from the ER, he may have to wait 48 hours or more on a stretcher because many beds are taken up by patients who are waiting for a place in a residential centre elsewhere. Finally, if he runs out of patience, he will call a journalist.

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[9] Morin, C. and Mayer, F. (2000), *Le faible revenu après impôt au Québec: état de la situation et tendances récentes.*

If a citizen goes to a CLSC for a medical problem, the response will depend on where he lives. In some CLSCs, physicians provide basic primary care medical services while in others, physicians only participate in specific programs. As regards home care, the citizen has the impression that clientele priorities vary according to CLSC and according to crises in the network. Basic social services are provided unevenly in CLSCs. Lastly, the citizen has had the impression over the years that CLSCs have been grappling with internal ideological divergences and conflicts over priorities which, in addition to funding problems, have slowed down their development. For the citizen, the question is still: Why is there no common core of effective and efficient services in CLSCs that is also consistent with local characteristics?

As regards continuity of services, the citizen has the impression that no one wants to take responsibility and he is caught in the middle. Just as he is generally quite satisfied with the personal care and services received, he is just as appalled at having to bear the cost of a fragmented and confused health care system. He does not understand why it is up to him to make the link between the various professionals who look after his case. He can't accept the fact that he is given appointments spread over four days for four diagnostic tests during the same care episode. He is tired of having to repeat the same story to different professionals and to bring his drugs every time because this information is not shared among them. He is distressed because he fears that this fragmentation works against his cure or rehabilitation.

Lack of access and continuity for health professionals

Health professionals also deplore this situation and the problems of access to diagnostic equipment and treatment. General practitioners often have trouble gaining access to specialized technical support centres, especially in medical imaging, and to consultations with specialists. They spend many hours trying to set up appointments for their patients. The waiting period for test results and consultation reports is very long. The hospital's ER then becomes the most effective and simple way to have access to consultations and specialized tests, thus overcrowding ERs. For specialists, access to operating areas and highly specialized equipment is restricted, especially for elective cases, which results in long waiting lists for their patients. When they have completely run out of patience, they convene a press conference.

Physicians, nurses and other health professionals also deplore the fragmentation of continuity of care. They often feel prisoners of "silos" that they have helped build with their trade unions, professional associations and managers. They feel that they no longer have the "power" or the ability to act as clinicians. Lastly, more and more physicians and their professional associations recognize the fact that the fee-for-service system does not encourage real case management of patients with complex pathologies or effective interdisciplinary work. Due to problems of organization, staff distribution and remuneration system, some specialists are providing too many primary care services while some general practitioners are providing too many secondary care services.

An organization of services that dates from the 1970s

In terms of work organization, budget allocation and administration, the organization of services reflects the reality of the 1970s. Today, too much value is still being placed on individual professional practice, the legal and budgeting autonomy of each institution, and operation in "silos" which mean that each service, department or institution can operate independently from the others. Everyone is urged to protect their field of practice, jurisdiction and budget. Moreover, the hospital is in reality the ultimate setting where medical and social problems are solved because of its round-the-clock, seven-day-a-week accessibility and availability of physicians. This is the perception of both the network and the population as a whole. Many studies show that, as a result, a high proportion of hospital-day utilization is clinically and financially inappropriate. This situation was tolerable when there was more money available and when the majority of interventions were less complex and could be carried out within the same institution. However, this is no longer true today. There is no one institution that does everything now. Thus, it is necessary to find out who does what and how to gain access to the various services, e.g., institutions, professional offices and community organizations. Moreover, whether these professional practices are medical or social in nature, they all need interdisciplinary work, communication and exchange of information. Thus, the organization of the health system must adapt.

Significant but incomplete adjustments

The health services and social services system has taken significant steps towards dealing with these new realities, especially in the area of organizational structures. The number of hospitals has been reduced and some facilities have been merged. Technological development has made it possible to change certain practices, such as reducing the length of hospital stays and the number of short-term beds, increasing day surgery and expanding – though still limited – home care. A number of activities have been shifted from the hospitals to the CLSCs, residential centres, physicians' offices, community organizations and the family. The same trend can be observed in the field of social services, that is, the reduction of institutionalization and the shift of activities to the family, the community and its organizations.

Nevertheless, the organization of services has not been able to adjust to these changes in a dynamic and adequate way but, rather, has simply endured them. All the more so because it has had to deal with major budget constraints over a short time period and a loss of expertise as a result of mass buyout of thousands of professionals. The result today is an organization which is in trouble and is experiencing growing problems of access and continuity.

A VISION: THE FAMILY PHYSICIAN AS THE STARTING POINT

Although the diagnosis was serious, the prognosis was full of hope. Many solutions for improving service organization were presented during the expert forums and the regional and national consultations. What should I, as a citizen, client and taxpayer, expect from an improved health care and social services system?

"I would first choose my family doctor. He is the one who can help me make choices about my health and health problems. He knows who I am. He knows my personal and family history, my lifestyle, health problems, social problems and my way of dealing with them. It doesn't matter where he practises – in a clinic or a CLSC – as long as he takes the time to listen to me and to understand me. He is a member of a team of 8 to10 family doctors practising group medicine. This team also includes nurses who are involved in health education and promotion activities and in managing problems. They perform tasks which complement those of the doctor and coordinate activities with the other professionals. Through service agreements, this team has access to CLSC professionals, i.e., the other nurses, the social worker, psychologist, dietician, occupational therapist and physiotherapist. It also has access to the various CLSC programs such as home support services and prenatal classes.

My family doctor who collaborates with the team nurse knows when and where to refer me for other medical and social services based on my needs. He is very familiar with the network of professionals, institutions and organizations that can help me maintain my physical, psychological and social health. He is in direct contact with specialists, with whom he can discuss my health condition should it become more complicated. He refers me to these specialists in their clinics or at the hospital if my condition requires diagnostic tests or further treatments. I have access to these tests and treatments within a reasonable period of time. My family doctor remains in contact with the specialist and continues the follow up when I return home. The same is true for certain specialized programs, for example, heart failure or the elderly who have lost their autonomy. If needed, my family doctor or his team nurse links up with the professionals in these programs to ensure continuity of care for me.

My family doctor collaborates with several other family doctors in his group or other groups in the territory so that there are enough of them to ensure round-the-clock, seven-day-a-week coverage, either in a CLSC, polyclinic or the ER at the local hospital, depending on the case. I still have access to the hospital's ER if I need it, but the ER is no longer the main point of entry to the care network. With the other family doctors in the territory, my doctor can hospitalize a patient (especially in peripheral and remote regions), participate in certain CLSC programs or follow up patients in the residential and long-term care centre. He is a member of a local or regional department of general medicine whose mandate is to evaluate the quality of the services that he and his colleagues deliver.

With my authorization, my family doctor and the other health professionals have access to the computerized data in my health record. This confidential record is the main tool for ensuring continuity of the services I receive, regardless which professional I see. This electronic link is particularly valuable for the pharmacist because it helps reduce prescription errors and preventable risks related to the wrong use of drugs. He makes sure that I do not undergo laboratory tests or radiology examinations that I have already had (which often happens) since he has immediate access to the latest results.

My doctor, the nurse or other professionals in the team or of the CLSC provide me with the relevant information on my particular health condition. They make sure that I receive the most up-to-date health promotion and disease prevention tools. They inform me about the various diagnostic and therapeutic means available to me and point out the advantages and disadvantages of each one so that, together, we can make the most informed decision about my health.

To sum up, in this vision, I choose my family doctor and he chooses me. An agreement is reached together, that is, we are partners in his team in the interest of my health, not necessarily for my entire life but for a fixed period at the end of which we will review the situation. This partnership agreement determines part of the remuneration paid to my family doctor and his team, an amount which is also defined on the basis of my personal characteristics and health needs.

My CLSC is also accessible to me for psychosocial needs. Whether I am grappling with a stressful situation because of a serious employment problem or my family is shaken because one of our teenagers has drug problems, I am sure to find a psychologist or social worker in my CLSC who can help us to properly assess the situation and find solutions. These solutions are implemented either by the basic CLSC team or in collaboration with more specialized resources and community organizations.

I can also approach my CLSC if my elderly parents need help to cope with their temporary or permanent loss of autonomy. I know that a team of professionals, in collaboration with the team's family doctor, can assess the situation and support me in seeking solutions, and link up with the different parties involved, such as the physicians' practice, the hospital, the residential and long-term care centre (CHSLD), and private residential resources.

I know that the most vulnerable or most isolated individuals do not always think to go to a CLSC. But my CLSC has set up specific programs to get in touch and take charge of these individuals, in collaboration with the family doctors, community organizations, and the other intervening parties in the network of services. To sum up, I know about all my CLSC's services and can use them since I know for sure that it is financed on a per capita basis, adjusted to the needs of the territory's population."[10]

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[10] Adapted from "Le point de départ: un bon médecin de famille," an article by Dr. Denis Roy, published in Le Devoir, 10 November 2000.

2.2 GUIDING PRINCIPLES

Is this vision of hope sheer utopianism? On the contrary, we believe that this vision is essential and is our major challenge for the years ahead. Two basic notions should be recalled here:

- A relationship of trust between a citizen and a health or social services professional who works in a team;
- A team of professionals who take on the overall responsibility for a clientele or population.

These professionals should be given responsibilities, conditions and means to make this vision a reality and work to improve the health of individuals and the population.

We are decidedly optimistic because concrete points of agreement on how services should be organized emerged out of the divergent views expressed during our consultations. We will use them as guiding principles to support our recommendations.

1) An organization that responds to the needs of individuals and of a population at every stage of their life:

- The pre-eminence of the citizen as an "expert" on his own health, with his rights and duties;
- The importance of the population's demographic, health and socio-economic characteristics.

2) An effective and efficient organization that aims at quality of care and services, excellent results, and that integrates:

- Health promotion and protection;
- Prevention of diseases and social problems;
- Delivery of health services and social services.

3) **New management dynamics focused on the results to be achieved rather than on the protection of professional, institutional, budgetary or union "silos":**
   - Flexibility and adaptability in the division of professional responsibilities and tasks as well as in work organization;
   - Use of incentives and contractual agreements instead of directives, rules and regulations.

4) **The prime importance of the work of clinicians, the necessity to restore their responsibility, power and means to act, as well as the possibility to evaluate them on the basis of their results:**
   - Emphasis on competence, creativity and initiative;
   - Clinical and financial responsibility that is decentralized and entrusted to teams of clinicians.

5) **The importance of integrated primary care medical and social services as the foundation of the health system:**
   - Focus on the needs of individuals and the characteristics of the population being served;
   - Emphasis on clinical case management and management of continuity of services;
   - Functional links with secondary and tertiary care services.

6) **An effective and efficient organization of social services in CLSCs:**
   - Basic psychosocial services in every CLSC;
   - Delivery of specific services for more vulnerable groups;
   - Functional links with health services and community organizations.

7) **The services of professionals used on the basis of their specific expertise and their ability to work in an interdisciplinary setting:**
   - Family physicians and specialists functionally integrated into the network;
   - Nurses and pharmacists recognized as essential clinical partners;
   - Professionals in the psychosocial field and the rehabilitation sector recognized for their specific contribution.

8) Complementarity and service "corridors" between local institutions and regional and national institutions:

- Decentralization of basic services and centralization of highly specialized services and advanced technology;
- Service contracts between institutions with mutual obligations;
- Flexible circulation of patients, professionals and information.

9) A culture of innovation, research and evaluation:

- Continuous evaluation of quality and continuity of services, client satisfaction, health outcomes and resource utilization;
- Curiosity about seeking new solutions, knowing what is being done in Québec and elsewhere;
- Decide, act, evaluate, adjust, decide, act, evaluate, adjust, ...

2.3 RECOMMENDATIONS

Our recommendations on the organization of services are grouped under eight major themes that include one or two general recommendations (R) and more concrete proposals (P).

- Prevention as an urgent need;
- Primary care social and medical services: the foundation of the health and social services system;
- Provision of basic services for the young and families;
- Networks of integrated services for specific clienteles;
- Coherent organization of specialized medical and hospital services;
- More responsibilities and greater accountability for physicians and nurses;
- More adequate distribution of physicians;
- Effective and secure clinical and management information systems.

2.3.1 PREVENTION: AN URGENT NEED

R-1 We recommend that

> Prevention be the central element of a Québec health and welfare policy.

This recommendation is supported by 8 proposals.

The health and welfare policy must carry a vision which will guide all actions related to health and social services. This policy, which is a true instrument of integration of the vision and values of Québec society, its choices and the orientations that it wishes to give to the health system, must become the basic tool for the Government of Québec and for all intervening parties and managers in the health and social services network. They must become the carriers of this vision and promote it to players from other sectors of activity so that it is adopted by everyone, thus transcending interministerial actions.

A renewed health and welfare policy should be structured around prevention of diseases and social problems as well as health promotion and protection.

It was shown in the previous chapter that health is a person's most valuable asset and that the primary goal of a health system is to improve the health of individuals and populations.

It is known that the health of individuals and populations can be affected by genetic factors and predisposition, lifestyles, socio-economic and environmental conditions, as well as by the health care and social services systems. Therefore it is not enough to ensure the quality of and access to the care system, but the causes affecting health must also be tackled. Care and services are essential, but if we are to act upon the causes of the problems, we have to start with the other health determinants.

For example, new viruses and bacteria are a danger to the health of populations and must be kept in check in order to control the development of communicable diseases. Some bacteria, which used to be controlled, are now resistant to antibiotics. Poor lifestyles such as smoking, physical inactivity and poor diet have major impacts on the development of cancer, lung disease and heart disease. The problems of mental health, alcoholism and drug addiction are associated with troubles adjusting to stress, family problems, lack of social support, and "general unhappiness." It is recognized that poverty and low educational level are linked to poor physical and mental health status and low self-esteem. The quality of the work environment and work habits also have an effect on health, for example, back trouble. Lastly, the quality of water, air and food, and the state of the roads are all environmental factors which have a major influence on the health of individuals and populations. Recent deaths as a result of contaminated drinking water in Walkerton, Ontario, and "mad cow" disease in Europe are but two examples.

Our public health system has a great number of medical and professional resources which, unfortunately, are poorly coordinated and sometimes compete with each other. There is little linkage between public health professionals and clinicians at the local level. We have read excellent documents on prevention that appear to not always meet their targets. In brief, there is a gap between theory and practice.

It is essential that a renewed health and welfare policy targets the major goals of health and social services. It is all the more important that these goals be translated into fairly concrete means of action and indicators of results so that the players can implement them at all levels of the system.

2.3.1.1 RESPONSIBILITY OF THE PLAYERS IN PREVENTION, HEALTH PROMOTION AND HEALTH PROTECTION

THE GOVERNMENT'S ROLE IN PREVENTION

P-1 We propose that the Government of Québec

- **Recognize its responsibility and overall accountability for the population's health;**
- **Give the MSSS the mandate to coordinate the analysis of the impacts of the policies and programs of all departments and major government agencies on the population's health.**

Given the importance of health determinants other than care and services, and of their impacts on health and the organization of services, the MSSS alone cannot shoulder (at the governmental level) the overall responsibility and accountability for the population's health. The Commission deems that they are first and foremost the responsibility of the Government of Québec.

Investing in health does not mean investing only in health care systems. When a government adopts measures aimed at providing access to higher education and reducing poverty, it is promoting better health for the population. When it contributes to improving the state of the water and sewage system, reinforcing the control of food quality, making roads safer, making vaccination accessible, it is protecting the population's health. When it promotes the creation of childcare centres, it is giving young children a chance to grow up in a positive environment. On the other hand, when it is slow in taking action in public health areas or directly or indirectly fosters behaviours that have negative effects on health (such as gambling), it tends to increase negative impacts on the health of individuals and populations as well as pressure on the MSSS. This is undoubtedly the reason why some people refer to the MSSS as the department of "consequences."

It is obvious that many government decisions have either positive or negative effects on the population's health. Thus, the government must make sure that it has the most information possible about these effects before making decisions. To this end, it must be able to rely on the expertise of the MSSS to provide it with these data and coordinate the impact studies needed.

THE ROLE OF THE MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX IN PREVENTION

P-2 We propose that the MSSS

- **Exercise strong leadership in health protection and promotion and disease prevention;**
- **Review health and welfare policy on the basis of the priorities identified at the local, regional and national levels, and by translating these priorities into means of action that institutions and professionals can adopt and implement.**

The MSSS must play a leading role in

- The development and transmission of knowledge on the population's health status to the public and the professionals;

- The development and transmission of knowledge on the best practices in health protection and promotion and disease prevention to the public and the professionals;
- The integration of prevention practices and their links with the organization of services into a reviewed health and welfare policy;
- Active health promotion with the population and various departments and organizations;
- The establishment of effective measures with its government partners and those in the health network and other sectors of civilian life, at three levels:
  - *Protection of the population's health*: these are environmental measures (e.g., quality of water, air, food, road system, vehicle safety, the work environment) or biological measures (e.g., vaccination against communicable diseases) that protect the population's health.
  - *Health promotion*: these are collective and individual measures aimed at promoting healthy behaviours in terms of lifestyles and work habits (e.g., healthy eating, physical activity, social network, upgrading skills and potential) or reducing behaviours that may be dangerous to health (ex.: smoking, drugs, alcohol, speeding). This is in fact health education.
  - *Disease prevention*: special measures which are added to or complement the health protection and promotion measures aimed at preventing a disease (e.g., cardio-vascular disease, cancer, diabetes) or a social problem such as spousal abuse or suicide. They can be primary prevention measures, i.e., to prevent or anticipate the appearance of a disease or problem; secondary prevention measures, i.e., to screen for the disease or the problem when it starts to develop in order to stop it from developing further or to better control it; or tertiary prevention measures, i.e., to reduce the negative consequences of the disease or the problem for the individual and his family.

The MSSS must take advantage of the expertise of public health professionals and use modern information and telecommunication technologies in order to exercise this strong leadership role in the field of prevention. It must also clarify the roles, responsibilities and accountability of everyone: the MSSS, the Institut national de santé publique du Québec (Québec public health institute), the regional boards and their public health departments, the CLSCs and physicians' offices.

THE ROLE OF HEALTH AND SOCIAL SERVICES PROFESSIONALS IN PREVENTION

P-3 We recommend that the public health departments

- **Inform health and social services professionals about effective prevention practices;**
- **So that they can be integrated into their clinical practice.**

Health professionals, whether working in an institution, in physicians' or other professionals' offices, have an essential role to play in prevention. When a physician, nurse, psychologist or social worker receives a patient for consultation, it is the ideal opportunity he and the patient take stock of the latter's physical and mental health status and social situation. It is also a chance to discuss the various ways of maintaining, improving and managing his health status.

If a health professional finds that certain physical or social conditions are common among a large part of his clientele or the population he serves (e.g., obesity, poverty, smoking, drugs, family violence), it is also another ideal opportunity for him to intervene. His work thus becomes more collective in nature. With his clinical colleagues, public health professionals and community organizations, he can contribute to developing preventive strategies to improve the conditions that have a negative impact on this population's health status.

Prevention practices must be an integral part of the clinical professional's "toolbox," whether he is in public or private practice. Moreover, he should be trained accordingly, he should have access to the expertise required, the relevant information and technical means, he should be able to take the time needed, he should be encouraged to work in prevention and be paid accordingly. Public health departments of the regional authorities must play a much more active role in the dissemination of knowledge on best prevention practices to health professionals.

THE CITIZEN'S ROLE IN PREVENTION

P-4 We recommend that the citizen

Be made aware of his responsibility in managing his own health and be given access to information for this purpose.

The citizen is responsible for his health. His primary duty is to find out and ask questions in order to be better informed about his health status and the ways of maintaining and improving his health. He must have access to information so as to be able to make informed choices about lifestyles, work habits, and the services he needs. He must develop his knowledge about his health status, the favourable and unfavourable conditions, the choices available and their predictable consequences. The citizen must appropriate his health in collaboration with health professionals. In a highly professionalized health system such as ours, this greater appropriation can only create a better balance between the "consumer" and the "producer." Thus, the public health department of the MSSS and the regional boards is responsible for adopting modern means of communication to better inform the citizens, in collaboration with the institutions.

Motivating citizens to take greater responsibility for their health also requires better education and a greater understanding of what affects health in order to both protect it and to avoid a disease or accidents. It appears that the earlier this awareness is acquired, the better the chances of developing and maintaining healthy lifestyles. Thus, we believe that schools should play a greater role in communicating knowledge about health and how the body works, in accordance with the developmental stages and the risks at different ages. Schools must also be transformed into an active environment where sports and physical activities are strongly encouraged and highly valued. Schools, being equipped for physical activities, should be more accessible to the entire community, in particular youth, especially outside school hours.

2.3.1.2 PRIORITIES IN PREVENTION

Many groups of public health professionals presented briefs to the Commission in which they all stressed the urgent need for prevention and the importance of setting priorities based on two criteria: the existence of preventive solutions that are known to be effective and efficient and their feasibility. They cautioned us against a short-term approach because in prevention, results generally can only be seen in the medium and long term. They expressed a number of priorities which we have adopted.

The choice of priority preventive interventions takes account of three major aspects:

- *Several risk factors are common to different pathologies or health problems.* For example, smoking is a major risk factor in the development of cardio-vascular diseases, respiratory diseases, and numerous types of cancer. Poverty is a major risk factor in the development of psychosocial problems and also an obstacle to the development of healthy lifestyles, thus causing health problems.
- *The first few years of life are crucial for the development of the health of individuals.* They are decisive in physical, psychological and social terms. That is the time when healthy or poor lifestyles are adopted, psychological and social behaviours develop, and when a high self-esteem and the perception of having control over one's life either do or do not develop.
- *According to the experts, the most effective preventive interventions are those that integrate the different developmental stages of problems* (primary, secondary and tertiary levels of prevention), *the different intervention settings* (primary, secondary and tertiary care, public health, family, community), *and are based on an approach centred on the life cycles* (childhood, youth, adulthood and old age).

We propose four themes of priority intervention in prevention and health promotion and protection:

- Preventive interventions with children and youth;
- Preventive interventions with adults;
- Preventive interventions with seniors;
- Health protection for the entire population.

The Commission deems that these priority interventions are important and must be integrated into all levels of the network of services while actively involving professionals. The MSSS must play a leading role in launching these programs and ensuring that the regional boards and institutions concerned implement them, in collaboration with their partners in civilian society as a shared responsibility.

PREVENTIVE INTERVENTIONS WITH CHILDREN AND YOUTH

Infant mortality has decreased considerably in Québec as a whole. However, the infant mortality rate and the birth rate of low-weight babies are higher in a poor community. The pregnancy rate among adolescents is also higher in poor and socially dysfunctional families. Among youth, there is an increase in smoking and problems associated with drug and alcohol abuse as well as problems related to being overweight.

The situations of vulnerability experienced by children and youth, especially within the family, have serious consequences for their development. Several studies show that early intervention can correct the risk-laden paths that these young people might take throughout their lives. It is important to maintain the line of action on early intervention proposed in the 1991 report *Un Québec fou de ses enfants*: "... Seize the opportunity. It's better to intervene intensively in the world of early childhood."[11] (translation)

P-5 For children and youth, we propose

- **Preventive services for pregnant women, new parents and young children (0-5 years old) living in an underprivileged environment;**
- **An education program for school-age children aimed at developing healthy lifestyles and appropriate social behaviours;**
- **A strategy adapted specifically for youth to prevent smoking and other addictions;**
- **A strategy aimed at preventing suicide among youth aged 12 to 18 years old;**
- **Wider accessibility to emergency oral contraception.**

PREVENTIVE INTERVENTIONS WITH ADULTS

Cardio-vascular disease, respiratory disease, cancer and injuries are the main causes of morbidity and mortality among persons aged 20 to 64 years old. Indeed, Québec has more smokers than the rest of Canada, and the number of people who are overweight or physically inactive is also increasing. Moreover, psychological distress and suicide are serious problems: Québec has one of the highest death rates by suicide compared to other industrialized countries, especially among men. Lastly, since 1981, the percentage of people aged 15 and over living alone has almost doubled.

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[11] MSSS (1991): *Un Québec fou de ses enfants*. Report of the working group on young people.

P-6 For adults, we propose

- An integrated program to prevent the main chronic diseases (cardio-vascular disease, respiratory disease, diabetes) including the development of healthy lifestyles among adults;
- The implementation of promotion-prevention measures and measures for early detection of cancer proposed in Québec's program for combating cancer;
- The implementation of the tobacco control action plan;
- The implementation of Québec's Strategy for Preventing Suicide.

PREVENTIVE INTERVENTIONS WITH SENIORS

Cardio-vascular disease, cancer, dementia, respiratory disease, and disease of the joints and muscular-skeletal system are the leading causes of morbidity and mortality among people aged 65 and over. Unintentional injuries (including falls at home), which are a major cause of hospitalization, can be linked to physical disabilities, disease of the joints, and drugs and alcohol abuse problems. While not denying the important contribution of drugs in improving the health and the quality of life of seniors, the appropriateness and optimal use of drugs should be systematically monitored.

P-7 For seniors, we propose

- A program of integrated preventive services aimed at:
  - improving their functional capacity and preventing the loss of autonomy,
  - improving lifestyles such as diet and physical exercise,
  - slowing down the progress of disabilities,
  - combating social isolation,
  - preventing injuries caused by falls,
  - increasing the safety of their own living environments;

- The improvement of programs for prevention, early detection and management of cardio-vascular disease, cancer, Alzheimer's disease, respiratory disease and disease of the joints and muscular-skeletal system;
- Programs to review the use of drugs and evaluate their therapeutic results.

HEALTH PROTECTION FOR THE ENTIRE POPULATION

Recent events such as contaminated drinking water in Walkerton, "mad cow" disease, agricultural pollution, contaminated blood, the Nile virus, respiratory problems due to air pollution, and resistance of certain viruses to antibiotics once again underline the vulnerability of our environment and the need to take measures to protect the population's health against physical, chemical and biological risks.

P-8 To protect the entire population, we propose that

- There be more monitoring of
  - the quality of water,
  - the quality of air,
  - the quality of food;
- There be more monitoring of communicable diseases and diseases that can be prevented through vaccination: vaccination programs, surveillance of certifiable diseases;
- There be more monitoring of occupational risks
  - through systematic evaluation and management of work-related physical, chemical and biological stressors.

2.3.2 PRIMARY CARE SOCIAL AND MEDICAL SERVICES: THE FOUNDATION OF THE HEALTH AND SOCIAL SERVICES SYSTEM

R-2 We recommend that

- **The organization of a primary care network constitute the main foundation of the health and social services system;**
- **This network be created on the basis of the current dual reality of CLSCs and physicians' offices.**

Both CLSCs and physicians' offices have been operating in Québec for at least 30 years. They have been established often in an atmosphere of opposition, sometimes indifference but rarely in a collaborative one. Physicians' offices were viewed as being outside the health network and CLSCs as not very conducive to the practice of medicine. However, both now have their own expertise and strengths. The offices, which have medical staff, carry out approximately 80 percent of basic medical consultations. CLSCs, on the other hand, have physicians and other health and psychosocial services professionals on their staff. Although, in general, they carry out fewer basic medical consultations, they provide promotion and prevention programs, psychosocial services, specific programs for vulnerable clienteles and other programs such as home care and home support services. In our view, it is time that this dual reality be recognized and their respective and complementary strengths be built upon. Rather than proposing a forced union, we propose a negotiated formal partnership. We believe that CLSCs and physicians' offices can provide individuals and the population with primary care medical and psychosocial services that are accessible, effective and efficient using an approach based on management and continuity of care.

2.3.2.1 CLSCS WITH A CLEAR MANDATE THAT INCLUDES AN ORGANIZED PRIMARY CARE SOCIAL COMPONENT

R-3 We recommend that

- **The social component of this primary care network come under the CLSCs;**
- **The MSSS specify the CLSC's mandate in view of providing a minimum common set of basic services throughout Québec;**
- **The CLSC be responsible for providing the population in its territory with basic psychosocial services.**

This recommendation is supported by 5 proposals.

As an essential player in the organization of integrated services in its territory, the CLSC must play a leading role and take on its responsibilities. We will not repeat what has been said for the last 25 years, that is, that the CLSC should be the point of entry to the health system. We believe that it is more realistic and useful to assert that the CLSC is an essential partner in the organization of primary care health services and social services.

A CLSC should provide the following services:

- Basic services in physical health, mental health and basic social services in a given territory;
- Clinical intervention and support programs for outpatients departments, programs for the elderly who have lost their autonomy and for palliative care;
- Programs of integrated activities for vulnerable or specific clienteles (e.g., mental health, occupational health, early childhood, youth, family violence);
- Community intervention activities aimed at having the communities take charge of themselves (e.g., healthy cities, towns and villages, community kitchens);
- Programs to support people in their living environment (e.g., home support services, work in schools and day care centres);

- A role as integrating centre aimed at coordinating resources within the sector and between sectors in a community (e.g., round table on youth, concerted action for a given clientele, work with social economy enterprises).

The CLSC's budgeting method must allow it to carry out its mandate and encourage it to conclude service agreements with physicians practising in *Family Medicine Groups*.

Conditions for success

- Refocus its energies on the priorities defined with the regional board,
- Ensure that its services are effective and efficient,
- Develop a culture of performance and evaluation,
- Identify its best practices,
- Stimulate innovation and creativity,
- Broaden its partnership with physicians' offices,
- Mobilize its team of professionals around projects of primary care integrated services,
- Measure client satisfaction,
- Be accountable to its population and its regional board for the following 7 points:
  - Goals of health outcomes,
  - Client satisfaction,
  - Type, quality and quantity of services provided,
  - Response to needs of the most vulnerable population groups,
  - Prevention activities,
  - Service agreements with physicians' offices,
  - Link with specialized services.

BASIC PSYCHOSOCIAL SERVICES FOR ALL INDIVIDUALS ASKING FOR ASSISTANCE

P-9 For individuals asking for assistance, we propose that

The CLSC be responsible for providing and ensuring access to basic psychosocial services for any individual in its territory who asks for assistance for himself or his family.

The CLSC is responsible for the following activities:

- Receiving and immediately assessing needs of individuals asking for assistance for themselves or their families;
- Ensuring round-the-clock, seven-day-a-week Info-Social services linked with Info-Santé services;
- Providing a minimum psychosocial response by suggesting an immediate intervention based on an intervention plan agreed on by the individual and the professional, or by suggesting an alternative solution to his needs;
- Referring and accompanying the individuals in need of assistance to the most appropriate services for their situation, either to other institutions, professionals or organizations in the private or public sector, and managing the continuity of these services, if applicable.

Conditions for success

- A round-the-clock, seven-day-a-week service organization that integrates the health and psychosocial components for telephone interventions and immediate on-site intervention;
- Protocols of evaluation, intervention and referral of requests;
- Access tools to territorial and regional resources (e.g., directories);
- Communication technology – telephone system, information systems – for personalized transfer;
- Multiskilled teams of psychosocial professionals: social workers, psychologists, psycho-educators;

- A mechanism for linking up medical teams and social teams in the CLSC or between CLSCs with the territory's medical clinics in order to ensure a comprehensive approach to individuals requesting services;
- A stand-by system of psychosocial workers who can intervene immediately in a crisis, outside office hours, by telephone or on-site;
- A mechanism for following up and exchanging information with the client to ensure that he has received the service required.

TARGETED PSYCHOSOCIAL SERVICES FOR VULNERABLE CLIENTELES

P-10 For groups and individuals in its territory who are vulnerable or in trouble, we propose that

The CLSC be responsible for fostering and ensuring access to psychosocial services targeted at groups and individuals in its territory who are vulnerable or in trouble.

The CLSC is responsible for

- Implementing strategies to identify vulnerable clienteles within its population;
- Taking measures to get in touch with the vulnerable clienteles in their own environment so as to provide them with the services needed;
- Providing different types of intervention: home support services, support for social integration, psychosocial services, more or less intensive psychological assistance, depending on the degree of vulnerability or distress, the degree of continuity, and the degree of chronicity or the duration of the problems;
- Identifying the complementary resources needed to respond to the needs of the clienteles who are vulnerable or in trouble.

Conditions for success

- Ensure the presence of workers in the community (e.g., for services to youth and families), be available for day care centres, schools and youth centres, in order to identify the needs of youth who are vulnerable or in trouble;
- Use reference systems: for example, birth notices, CLSC/youth centres protocols, school-CLSC agreements;

- In close collaboration with the local partners, develop means to identify vulnerable clienteles;
- Develop basic psychosocial intervention[12] with a view to
  - supporting individuals in their relationship with their environment,
  - providing personalized support to parents and family acting as caregivers,
  - developing abilities, psychological support and respite/relief services,
  - social integration at home, school, work and in the community,
  - supporting community life so as to help communities establish conditions that are favourable to the health and welfare of their more vulnerable members.
- Develop with other CLSCs a program-based approach to issues that go beyond the strict boundaries of its territory.

Targeted social services are basic services that are provided to vulnerable or at-risk population groups due to their particular temporary situations (e.g., stages of life, job loss, bereavement, disease) or more permanent situations (e.g., impairment, loss of autonomy, poverty, violence). These services are also provided to individuals, families or groups who have serious problems, in the short or long term.

The CLSC is responsible for getting in touch with the most vulnerable clienteles in its territory and ensuring that they receive the assistance best suited to their condition and situation. Thus, it must take into account the "disadvantage" indexes of settings and communities in its territory in order to be able to target groups who have high-priority needs. It must also implement a set of basic services for the targeted clienteles.

The service provision described here does not mean that CLSCs take no part in clienteles without serious problems. The same is true for seniors who do not ask for special services. CLSCs must provide prevention programs such as the annual influenza immunization and programs whose goal is to protect and promote good health among seniors.

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[12] The distinction between basic psychosocial services and specialized services would be made according to clienteles' needs.

THE CONTINUITY OF SERVICES PROVIDED

P-11 With regard to continuity of services, we propose that

The CLSC be responsible for managing continuity of the services provided to the vulnerable clienteles and individuals in trouble in its territory.

The CLSC is responsible for

- Coordinating the follow up of services provided to individuals by acting as a personal guide and supporter;
- Developing and implementing the approach and responsibility of a key intervening party;
- Monitoring the services provided.

Conditions for success

- Personalizing continuity of services by designating a key worker to support the client in seeking the services needed and to act as a guide or an assistant depending on the client's situation and, if necessary, as a coordinator of the service plan;
- Managing continuity means that the CLSC can refer a person to one of its internal programs, to another institution of the network, a community organization or a professional working in the private sector;
- A network of integrated services for the elderly requires the presence of a key worker to ensure continuity of service;
- To carry out its mandate and manage continuity in the sector of services for youth and their families, the CLSC must take into account the special role of the Director of Youth Protection.
- The following is a concrete example of a promising experiment
  - The Accès Jeunesse Toxicomanie Program (PAJT, youth access addiction program) in the Québec City region where institutions have set up one-stop access to an evaluation process which is a dynamic link between general services and specialized resources. This means that the most appropriate resources will take charge of the young person.

COORDINATION OF COMMUNITY RESOURCES

P-12 With regard to coordination, we propose that

> **The CLSC be responsible for coordinating the community resources required to respond to the needs of its population.**

To lend support to the territorial organization in carrying out its responsibilities in service provision, the CLSC must create, with its partners, prevention programs that are related to the community's needs. These programs are characterized by their responsiveness and their capacity to adapt to the evolving needs of the community.

The CLSC is responsible for the following actions:

- Establish service agreements with institutions in the health and social services network, cross-sectoral service organizations such as school boards, childcare centres, municipal services and community organizations;
- Set up mechanisms for cross-sectoral consultation and facilitation of communities so as to determine the needs of its population and develop promotion and prevention strategies for the health and welfare in its territory;
- Inform the population on a regular basis about psychosocial services and resources available to them.

Conditions for success

- Set up a system to identify needs and, to this end, make use of the knowledge of the regional board's public health teams;
- Develop indicators and implement means to identify vulnerable groups and individuals;
- Adopt means to identify and list all the services and resources working with the population in its territory;
- Take the initiative, based on a cross-sectoral approach, to implement joint programs and projects that are likely to provide solutions before the situations get worse.

INCREASED INVESTMENT IN SOCIAL RESEARCH

P-13 To improve social practices, we propose that

> **The MSSS, in collaboration with the Ministère de la Recherche, de la Science et de la Technologie and its Conseil québécois de la recherche sociale, foster the rapid development of research on the evaluation of social practices and approaches and on the social determinants of health.**

The quality, effectiveness and efficiency of social services depend on the systematic evaluation of social practices and approaches as well as on a better understanding of the effect of social determinants of health.

To measure performance, there need to be agreed-upon, highly reliable indicators to measure the achievement of the expected results. It is difficult to see how a productive assessment of the social practices and results could be conducted without first defining the analytical frameworks and the indicators of results.

Given the impact of social determinants (poverty, low education level, etc.) on health, the Commission deems that it is important to speed up research studies in this field, to invest the appropriate budgets in them, and to apply knowledge to professional practices.

2.3.2.2 A PRIMARY CARE MEDICAL SERVICE BASED UPON *FAMILY MEDICINE GROUPS*

R-4 We recommend that

> - **The medical component of this primary care network be made the responsibility of *Family Medicine Groups* that include general practitioners working in a group, in an office or a CLSC with the collaboration of nurse clinicians or nurse practitioners;**
> - **These *Groups* be responsible for a range of defined services for a population of citizens who chose these general practitioners.**

This recommendation is supported by 2 proposals.

Family physicians would be grouped into teams of 6 to 10, either in offices or CLSCs. These physicians would work in close collaboration with 2 to 3 nurse clinicians or nurse practitioners who take part in the management and coordination of services. This *Family Medicine Group* would be responsible for a definite number of patients (from 1,000 to 1,800 citizens per physician) and provide it with a range of specific services.

Each citizen would choose his family doctor within the *Group*, on the basis of his place of residence, his workplace or any other criterion. This choice would be expressed through "voluntary registration," that is, a mutual agreement between the citizen and the physician for a fixed period (e.g., 6 months), with the possibility of changing at the end of that period. It must be emphasized that, currently, patients who have a family doctor tend to keep him. The same is true of physicians with their patients. The goal is to preserve, even to reinforce the concept of doctor-patient relationship and, eventually, to allow all those who so wish to have a family doctor.

On the basis of this agreement, the physician and his *Family Medicine Group* would undertake to provide primary care within a reasonable time limit, 24 hours a day, 7 days a week, at the most appropriate setting. The agreement would relate to a number of activities: management and follow up of health status; health promotion and disease prevention; diagnosis, treatment and follow up of acute and chronic care episodes; request for consultation with secondary and tertiary care medical services; management of continuity of services; request for psychosocial consultation; networking with other *Family Medicine Groups*, the CLSC, the CHSLD, or the general or specialized care hospitals; use of specific programs depending on the needs of the *Group*'s clientele and the CLSC's population. For example, the *Family Medicine Group* could participate in the development, with the secondary care and tertiary care levels and the CLSC, of programs to manage medical problems such as heart failure, certain forms of cancer, diabetes, and Alzheimer's disease as well as the provision of palliative care.

Depending on the agreements, the *Group* will participate with the CLSC in an integrated management program for seniors who have lost their autonomy and individuals suffering from severe mental illness. It could act as a medical consultant to the CLSC for population groups who are socially vulnerable.

Nurse clinicians or nurse practitioners who work within a *Family Medicine Group* would carry out prevention/promotion activities; clinical screening activities; a number of diagnoses/treatments in agreement with the group of physicians; case management activities; and liaison activities with the CLSC and secondary care services.

P-14 With regard to payment, we propose

- A mixed or blended system of payment for family physicians;
- A new contractual agreement system between the *Family Medicine Groups* and the regional department of general practice (DRMG) of the regional board;
- Service agreements between the *Family Medicine Groups* and CLSCs.

The family physician who works in a *Family Medicine Group*, in an office or a CLSC, would be paid according to a mixed system: an amount based on the number of people registered and their health and social characteristics; a lump sum for participation in certain programs (CHSLD, emergency, CLSC programs, vulnerable population groups, etc.), according to contracts or agreements; and a fee-for-service amount either for specific prevention activities or to support productivity in high-volume activities.

Each regional board and its DRMG would be responsible for organizing and coordinating these primary care medical networks in which the *Family Medicine Groups* participate, and would encourage the signing of service agreements between these *Groups* and the other primary care resources, in particular the CLSC, but also the CHSLD and the local hospital in certain cases. This would ensure the availability of all primary care medical activities for a population.

By entering into an agreement with the regional board's DRMG, the *Family Medicine Group* would have access to, in addition to the CLSC's nurse clinicians or nurse practitioners assigned to the *Group*, other professional resources of the CLSC based on a service contract signed between the parties (dietician, physiotherapist, occupational therapist, social worker, psychologist, home care team, and other specific programs). The *Group* would have access to the pharmacists of the institution and should develop links with pharmacists in the community.

We propose that there be a financial support program for groups who would like to quickly get established. This program would facilitate computerization and connection with the health and social communication network (RTSS), real estate transactions for the purposes of reorganizing in groups, and access to an adequate technical support centre. The group would have access to mechanisms for professional training and would be subject to a system that evaluates the quality of service organization, under the authority of the regional department of general practice (DRMG) of the regional board. The evaluation would focus on the effective organization of primary care medical services to the population served by the group, the agreements with the CLSCs and secondary care services, the goals of promotion and prevention, and the management of continuity of services.

The regional board would be responsible for ensuring the availability of medical and nursing staff; providing the *Group* with the necessary infrastructures or ensuring adequate financial compensation if the *Group* has to develop these infrastructures; respecting the *Group's* clinical autonomy, and giving the *Group* sufficient manoeuvring room to achieve its goals, which will be evaluated.

P-15 To support the implementation of *Family Medicine Groups* throughout Québec, we propose that

- **A group be set up to support the implementation of a family medicine network;**
- **This group be led by a well-known family doctor; and**
- **That it be composed of clinicians (physicians, nurses, other professionals) recognized for their expertise and working in the primary care setting.**

This *Group*, which comes under the authority of the MSSS, would be a "champion" of this primary care vision. It would collaborate closely with the DRMGs and regional boards to specify operating conditions and identify the factors of success; stimulate and foster the development of projects; help with the organizational and operational aspects of projects; intervene with various authorities to iron out difficulties; and ensure continuous evaluation of projects. This non-permanent *Group* whose term would be predetermined, would have a budget to support its implementation in order to provide the incentive for the establishment of projects.

The Commission is aware that the organization of primary care medical services structured around *Family Medicine Groups* and CLSCs cannot be implemented rapidly everywhere. We believe that it should be carried out gradually with family physicians and CLSCs that are interested in implementing this type of project. We believe that physicians should be encouraged to support the project voluntarily and that CLSCs should be encouraged to collaborate. At the same time, physicians who take part in the project should see their living and working conditions improve compared to those who choose to practise on their own. Similarly, participating CLSCs should benefit from budget incentive measures.

The goals should be as follows. At least 30 to 40 projects should have been created in Québec within one year and, within 5 years' time, 75 percent of the Québec population should be enrolled voluntarily in a *Family Medicine Group*, either in an office or a CLSC.

We propose a vision and goals but do not expect to have defined everything in detail before this vision can be implemented. Rather than imposing a single, detailed model everywhere, let's move forward with those who share this vision and want to achieve it. Let's support them, facilitate their work, define the ways and means with them as we proceed, evaluate the activities and adjust accordingly. In other words, let's act, move forward, evaluate and adjust. This strategy, recommended to the Commission by several international experts, is, in their view, the key to the successful transformation of the health network in many countries.

2.3.3 PROVISION OF BASIC SERVICES FOR YOUTH AND FAMILIES

Acute problems

Support for the development of children and youth has long been one of the main concerns of the government and the subject of a broad consensus among the general public. However, speeches and reports are not always followed up by action. Violence committed against children, families living in poverty, school dropouts, drug and alcohol consumption among youth, suicide, the phenomenon of gangs, the problem of access and quality of services in some youth centres, the lack of resources in CLSCs and schools, all these problems regularly make the newspaper headlines. Without appropriate and early support, social problems proliferate from one generation to the next and generate human, social and financial costs in the medium and long term.

The costs generated by problems experienced during childhood and adolescence are well documented. The result is:

- Marginalization and under-qualification resulting in low self-esteem and dependence on state assistance (income security): "Youth from a poverty-stricken environment are more likely to live a good part of their lives on government benefits;"[13] (translation)
- Under-qualification coupled with loss of revenue for the state as shown by, for example, the results of the Doherty[14] study which reveal that a man with a diploma will pay four times as much tax to the state as somebody who has not finished high school; this ratio is 16 to 1 for women;
- Increased utilization of health care since underprivileged and vulnerable individuals have more health problems. Many studies confirm that the effect of social inequalities on health costs is reversible and that intensive measures to support children and families can have a significant impact on life;
- High consumption of medical services for health and social problems that could be solved more adequately elsewhere.

Thus, "social health" exists and directly affects the physical health status of citizens[15] and also has a direct influence on society's "economic health."

Incomplete and fragmented services

It is generally agreed that there is a lack of basic services for youth and their families. Half of the 50,000 cases reported to the director of youth protection are not retained because they do not meet the criteria of the *Youth Protection Act*. Although these reported cases are not considered serious enough to be retained, it nonetheless remains that a large proportion of these youths are very likely in a situation that may, in one way or another, be detrimental to their development. An organization of properly integrated services that provides continuity in intervention would avoid many reported cases and prevent certain situations from getting worse. Due to the lack of well organized and accessible resources both upstream and downstream, the youth protection department (DPJ) has become a kind of "hospital emergency," i.e., a point of entry as well as a last-resort route.

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[13] Brief from the Association des centres jeunesse du Québec (Quebec association of youth centres), October 2000.

[14] See Le Sommet du Québec et de la jeunesse (1999): *Promouvoir une société équitable*. Working report. Government of Québec.

[15] See the most recent results on l'Enquête Santé Québec (Québec Health Survey) on the effects of poverty on health status.

Many organizations such as childcare centres, schools, CLSCs, and youth centres work with youth, but there is very little communication and cooperation between them. Interventions are fragmented according to these organizations' initiatives, based on available resources. Services differ and practices are fragmented. It is the young in need of services who bear the cost of the lack of resources and this fragmentation: the intervention is carried out too late, when the situation has become a crisis.

The Commission believes that action that is better linked and more cooperative guarantees healthier individual and social development for youth and families. In our view, this urgently needs to be made a matter of high priority and that it should be adequately financed and acted on.

R-5 We recommend that

- **All Québec CLSCs be responsible for developing, with their partners, a common core of basic services provision for youth and families, and be accountable for it;**
- **This provision be implemented within the next 5 years.**

This recommendation is supported by 5 proposals.

A working group, bringing together all the intervening parties of the departments involved, public health departments, youth centres and CLSCs, has developed a provision of essential services for youth and families that all CLSCs in Québec[16] should provide. This is the result of a concerted approach and, in the Commission's view, must be implemented as soon as possible.

The provision of basic services is as follows:

- It integrates universal measures for all youth and families and selective measures for clienteles who are vulnerable or in trouble, targeted by the CLSC;
- It integrates health services and psychosocial services;
- It integrates promotion and prevention interventions and service delivery to youth and families who are vulnerable or in trouble.

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[16] Association des CLSC – CHSLD du Québec, *Allons à l'essentiel. L'offre de services Famille/Enfance/jeunesse en CLSC*, October 2000.

To this end, the CLSC must provide:

- Perinatal services: prenatal contacts and meetings; consultation after birth or international adoption; intensive support for vulnerable families through programs such as *Naître égaux* and *Grandir en santé* and *OLO*; links with family physicians and pediatricians; links with the community organizations involved;
- Basic health care services: vaccination, dental care, health records in day care centres and at schools, youth clinics;
- Services to support child development: support for parental skills, speech therapy, early stimulation in day care centres for vulnerable children; parents-schools linkage;
- Assistance and consultation services for youth and parents in distress: psychosocial consultations, respite/relief, support for families who have a child with a mental or physical developmental disorder;
- Community mobilization services.

The CLSC must provide these basic services at all of the young person's developmental stages, taking into account the changing needs and the sensitive areas specific to each age group.

We are aware that the organization of basic services for youth and families will require additional investment. However, we propose that CLSCs start providing these services soon, using the resources that they already have, and adapt them to the specific characteristics of youth and families in their territory. We believe that as this provision takes shape, CLSCs will be able to determine more clearly and justify the level of additional resources needed.

AN AUTHORIZED AGENT FOR YOUTH SERVICE COORDINATION

P-16 For the coordination of youth services, we propose that

Each CLSC or group of CLSCs appoint a person responsible for youth services to coordinate health services, psychosocial services and cross-sectoral interventions.

In the field of youth services, the Commission found that services and resources are available in the territories, but there is a lack of integration and coordination. While not putting the brakes on local initiatives and creativity, the Commission deems that the responsibility and accountability for coordination should be given to one person only, an essential factor in further integrating services to children, youth and families.

The person responsible would coordinate

- The provision of basic health care and psychosocial services, in terms of both basic services and targeted services, for youth and families in their territory;
- Cross-sectoral interventions, in particular to support the CLSCs in their work with childcare centres, schools, *Family Medicine Groups* as well as the local community organizations.

This coordination would consolidate the interdisciplinary and cross-sectoral practices and would make interventions more consistent and resources more coherent, which would in turn improve the effectiveness and efficiency of services and interventions.

The coordinator of youth services must be an experienced manager who is known and has credibility in his environment, both within the CLSC's team of Family / Childhood / Youth services and with the network's partners and cross-sectoral and community partners. We believe that this coordinator must be accepted by the partners and, to this end, we propose that they take part in defining the profile sought and in the selection process and that they pay part of the salary.

FOR A REVIEW OF THE *YOUTH PROTECTION ACT*

P-17 So that children whose case was reported but not retained or who were considered not to be in a situation of danger after evaluation by the director of youth protection can benefit from adequate services, we propose that

- **The *Youth Protection Act* be reviewed;**
- **The general protocol linking the youth centres and CLSCs in the territory be updated in each region;**

The *Youth Protection Act* has existed for 21 years. New social realities have emerged since then and new laws have been adopted, including the *Young Offenders Act*. Moreover, in recent years, the Québec system of youth protection has frequently been called into question. The Commission deems that it is necessary to review the *Youth*

Protection Act in order to better protect the child's interests and take these new realities into account.

There is a broad consensus on the lack of basic services to respond to requests for assistance from families and youth and to support those who are most vulnerable. The data available on youth centres show that 25,000 cases reported to the youth protection department (DPJ), that is, 50 percent of all reported cases, were not retained because they did not meet the strict criteria of the law which requires that the security and development of the child be endangered before the reporting can be retained. A less specialized intervention that is adjusted to the seriousness of the situation would certainly prevent the situation from degenerating and the child from ending up under the protection of the DPJ with all the consequences that this involves when the child is taken charge of too late. In addition, a great number of children come back under the protection of the DPJ after having been subject to intervention, due to a lack of social support and less specialized resources which would help consolidate the gains made and support youth and parents.

Rapid, preventive and timely action, half-way between no intervention at all and highly specialized intervention by the DPJ, would certainly be desirable so as to prevent children from being put under protection of the DPJ whenever possible. To this end, all youth services such as childcare centres, schools, CLSCs, community organizations and youth centres, must participate and work together as a network rather than each one not knowing what the other is doing for the youth in question. Thus, for example, under the *Youth Protection Act*, a youth centre cannot refer a youth to the CLSC for follow up, without the consent of his parents or of the youth himself, if he is aged 14 or over. The provisions in the law on respect for confidentiality are clear.

However, currently, it is difficult to take a rapid, preventive and timely approach because institutions work in isolation from one another. Several institutions assume responsibilities for the same youth without communicating and consulting with each other. Although institutions provide some continuity of services within their own organization, it seems that none of them is responsible for ensuring continuity of services with others since information that is necessary for ensuring this continuity can only be communicated within the same institution. Without a formal protocol for communication between partners, the child may loose the benefit of an appropriate intervention, in particular when primary care services could be sufficient.

The Commission is aware of the utmost importance of managing confidentiality and protection of personal information. Nevertheless, it agrees with the views expressed by many groups that the constraints imposed by the *Youth Protection Act* have irreversible consequences for the youths who must be protected. Thus, many of them are caught in a dilemma and have no safety net. There is no simple solution for this complex problem. That is why the Commission considers that it is absolutely essential that the *Youth Protection Act* be reviewed. The recent conclusion of protocols between a number of CLSCs and youth centres, which allow for the transfer of a voluntary request for intervention, agreed to by the parents and the youth aged 14 or over, to primary care services, is certainly a step in the right direction. The CLSC thus becomes responsible for managing the case. Effective follow up between the youth centre and the CLSC could result in:

- Better upstream intervention;
- Management of reported cases that were not retained;
- Better downstream follow up of youths who have been under the protection of the DPJ and whose immediate security and development are no longer endangered.

A RENEWED MSSS-MÉQ AGREEMENT

P-18 For a cross-sectoral action that is further integrated with youth, we propose that

The MSSS-MÉQ agreement be renewed and that the Ministère de la Famille et de l'Enfance and the childcare centres also be included.

Coordination has existed for many years between the Ministère de l'Éducation (MÉQ, Québec department of education) and the MSSS. However, we believe that it must be reviewed in depth because the environment that gave rise to this coordination has changed considerably.

With all the restructuring and cutbacks, schools have had a tendency to strictly focus on their educational projects, thus reducing the importance of support resources in the overall projects of schools. In our view, schools have a responsibility that goes beyond academic learning. The school is a living environment for the child and a partner in an organization of services for the young. In that capacity, it has the obligation to coordinate with other service providers. We also believe that schools must provide the support services that children need in order to learn. In a context where children's social and emotional problems are on the rise, we found that the services of psychologists and adjustment teachers are still underdeveloped.

A new important player has also appeared in childcare services. The Ministère de la Famille et de l'Enfance (MFE) has also become an operating agent in the education sector and is, with the childcare centres, a point of entry to health services. In our view, bipartite agreements between the MSSS and the MÉQ must be changed to tripartite agreements that include the MFE. There is a need to redefine joint responsibilities and to decide on the resources that the three departments are willing to consent to, based on an approach of continuity and complementarity of services.

In fact, the complicated situations experienced by children and their families and the challenges of learning in a modern educational project require very close cooperation between all the intervening parties. This revised agreement should strive to

- Define the level of resources needed;
- Clarify the roles and responsibilities of each and everyone;
- Involve local players, i.e., schools, childcare centres and CLSCs;
- Define the joint responsibilities of these local players;
- Specify the mechanisms for cooperation and follow up of agreements.

HIGH QUALITY STANDARDS FOR YOUTH CENTRES

P-19 To improve the services provided in youth centres, we propose that

> **Youth centres speed up their process of improving practices, defining high quality standards and training their workers.**

Even if significant efforts are invested in basic social services, there will always be a need for youth protection. Some citizens, due to mental disorder, alcoholism, drug addiction or other problems, cause their children to live in situations that endanger their security and development. These citizens may not be in a position to assume their family and parental responsibilities for a relatively long period.

In these cases, the *Youth Protection Act* must be used and a network of specialized services must be available to rapidly protect the children whose security and development are endangered. Specialized services for families whose needs exceed the capacity of the basic social service resources are provided by Québec youth centres.

Furthermore, society must also be protected against the dangerous behaviours of emotionally disturbed adolescents, such as crimes against persons, assaults, and so on. In recent years, the youth centres have been successful in implementing the *Young Offenders Act* in an innovative way, thus creating the right balance between protecting society and rehabilitating the adolescent. The approach chosen by Québec to apply this federal law must be maintained.

The network of youth centres has a long history of intervention with troubled youths. However, the quality of services of a number of these youth centres has recently been called into question. The Commission urges the MSSS and youth centres to speed up the measures that they themselves have identified.

- Invest in the quality of practices of specialized social services, which requires considerable effort in training workers, applying generally accepted standards of practice, and in management centred on quality control.
- Establish stable funding on the basis of real costs of service production as well as best practices rather than on an historical basis.

A FINANCIAL INVESTMENT IN "CHILDHOOD AND YOUTH": A SOCIAL PRIORITY

P-20 To consolidate the provision of basic services to children and youth, we propose that

Beginning in 2001-2002, the MSSS holds an amount of $20 million per year, for 5 years, in its future development funds.

The growing difficulties experienced by youth and their families and the importance of early and intensive intervention with youth require that a specific and sustained investment be devoted to them. With the financial effort made to date, CLSCs have not been able to provide youth and families all over Québec with basic services that are adjusted to the levels of vulnerability.

We estimate that some one hundred million dollars are needed to finance these basic services. This amount should serve only for direct delivery of basic services to youth and families as well as for local coordination.

The CLSCs that are most dynamic in the area of youth services should, on the basis of implementation projects, give a budget allowance to the person responsible for youth services. This will be used to purchase services, carry out special projects or other types of action adapted to the needs of youth and their families, and also to assess their impact.

2.3.4 NETWORKS OF INTEGRATED SERVICES FOR SPECIFIC CLIENTELES

R-6 We recommend that

Networks of integrated services be created, in particular for specific clienteles such as:

- **The elderly who have lost their autonomy;**
- **Individuals suffering from serious mental health problems;**
- **Individuals affected by complex diseases which are often chronic.**

This recommendation is supported by 4 proposals.

2.3.4.1 THE ELDERLY WHO HAVE LOST THEIR AUTONOMY

Compared to other Western societies, population ageing in Québec will accelerate in the coming years. The population aged 65 and over will increase from 12.6 to 24 percent between 1999 and 2030.[17] This demographic growth of the elderly, both in number and in proportion, is due to our parents' high fertility, baby boomers' low fertility and the success of public health measures and medical and pharmacological interventions.

Thus, there will be more and more elderly people in the coming years. Many will be in good health and actively contribute to society and will very often continue to pay taxes.

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[17] Ministère des Finances du Québec, 2000 (see Figure 10, Chapter 4).

Depending on their health status, appropriate medical and social interventions, technologies and drugs will help improve their quality of life and reduce mortality and morbidity. However, approximately 20 percent of seniors have disabilities and need help in daily activities. This situation affects their families and friends who must deal with these new needs.

Moreover, the elderly who have lost their autonomy are affected by complex problems, that is, acute and chronic medical conditions very often associated with psychosocial problems, disabilities in daily activities, and often a weakened social network.

The organization of services is also problematic. It is difficult for the elderly to gain access to services and their needs are poorly met mainly because of the fragmentation of services, the lack of clear responsibility and accountability, and the lack of incentives for interdisciplinary work between the medical and social settings. Consequently, due to the methods of management and budgeting, the "heavy" resources – hospitals and CHSLDs – are often used in a clinically inappropriate way, a large proportion of the health and social services budget being devoted to them. Lastly, real management and coordination of continuity of services are often lacking. Finally, geriatric-type interventions are often inadequately used and medical, nursing and social staff are not very well trained for this gerontological/geriatric reality.

However, we should avoid thinking in deterministic terms and automatically projecting current costs based on the predicted growth in the number of seniors. Health promotion and disease prevention activities, current and future new treatments for chronic diseases as well as better medical and social case management will have an impact on quality of life and thus, there will be many more seniors who live longer in good health. In Québec and elsewhere, emerging experiences in integrated services for the elderly who have lost their autonomy show that it is possible to efficiently change their profile of resource utilization while providing them with better quality and more continuous services.

Guiding principles

The transformation of the network's current organization should be pursued so as to better respond to the needs of the elderly who have lost their autonomy and provide them with quality care and services, based on better cost effectiveness. The network of integrated services for seniors must be seen as an essential component of the system and must be governed by 5 guiding principles:

1) The capacity to provide a complex set of services

The elderly who have lost their autonomy need to receive, in the most appropriate settings, a complex set of health services for acute and chronic conditions and social services as well as support services for daily activities and home care.

2) Use of the most appropriate resource

This means using the appropriate primary care resources in the most relevant and flexible way. These resources can be medical, social or support-type and can be delivered in a public institution or a professionals' office, in the community sector or private sector. In this way, inappropriate use of hospital and institutional resources will be reduced. In short, the goal is to use the most appropriate resource, in clinical, human and financial terms, while ensuring quality, regardless of the setting.

3) Integration of services

Emerging experiences show that it is necessary to develop networks of integrated services for the elderly who have lost their autonomy, based on the organization and provision of primary care services for a specific population. The team who works in these networks takes on the clinical responsibility and the management of continuity of services, regardless of the provision setting. Case management by a case manager or key worker is an essential tool for the coordination and integration of services. The financial responsibility for services, linked with the clinical responsibility, becomes an additional tool for integration and accountability.

4) The clinical gerontological-geriatric approach

The gerontological-geriatric approach emphasizes the importance of prevention and early medical and social case management. It stipulates that evidence-based interventions can have a positive effect on the progression of the disease, disabilities, quality of life and satisfaction of individuals as well as on the use of resources.

5) Training, research and evaluation

It is essential that professionals and other primary care workers have specialized training, in particular in geriatrics. It is also necessary to pursue research on geriatric syndromes and related psychosocial problems, and on the organization of services for these people. The development of projects and networks must be rigorously evaluated.

These same guiding principles can be adapted so that they can then be applied to the networks for individuals suffering from a serious mental health condition or for those suffering from complex, often chronic diseases.

NETWORKS OF INTEGRATED SERVICES

P-21 For the elderly who have lost their autonomy, we propose that

The regional boards initiate and supervise the creation of networks of integrated services and entrust the CLSCs with the responsibility for these, in collaboration with the *Family Medicine Groups*.

These networks would include the 5 following components:

1) The regional board fosters the development in specific territories (e.g., CLSC, RCM, neighbourhood) of networks of integrated services for the elderly who have lost their autonomy. These networks have the clinical and financial responsibility for health services, social services and support services for this clientele. Emerging experiences in Québec can be used as a model for the board.

2) The regional board ensures that the CLSCs together with their multidisciplinary home care teams develop contractual agreements with the *Family Medicine Groups*, or with physicians in offices where the *Groups* have not yet been implemented. These agreements specify the procedures for managing a specific population of seniors who have lost their autonomy, that is, the following activities:
   - Identification of individuals and their follow up;
   - Management by the same case manager, regardless of the setting of service delivery;
   - Management of prevention, treatment, rehabilitation, palliative care, assistance to family members;
   - Use of protocols of gerontological-geriatric evaluation and intervention;

- Management of long-term medical and social problems as well as acute episodes; management of transition between home and hospital and vice versa; day care service;
- Use and mobilization of resources in a rapid and flexible way, including support services and alternative residential resources;
- Linkage with specialized services, in particular geriatrics and gerontopsychiatry;
- Linkage with short-term hospital and the CHSLD.

3) The regional board encourages the establishment of a specific budget based on the number of elderly persons under its responsibility or a budget for the "non-autonomous elderly" that is related to the clinical responsibilities of the network of integrated services. This budget should gradually include the costs of services in the different institutions (CLSC, CHSLD, hospital), in private residential or home support resources, and the costs of drugs (RAMQ). It would also integrate the funding from an eventual capitalized loss-of-autonomy insurance plan, which will be described in Chapter 4. Thus, the service "purchase" function will be introduced and will gradually be separated from the service "production" function.

4) The CLSC is responsible for managing this program in collaboration with the *Family Medicine Groups*.

5) Given the complexity of implementing projects and the specific characteristics of the regions, we propose that implementation projects be started in each of the regions. Once again, the same approach should be adopted here: decide, act, evaluate and adjust.

INCREASING HOME SUPPORT AND RESIDENTIAL RESOURCES

P-22 To ensure a quality of life for the elderly who have lost their autonomy, regardless of their place of residence, we propose that

- **The provision and intensity of home care and residential care services be increased globally;**
- **The quality of services and respect for dignity be ensured, regardless of the place of residence and type of accommodation;**
- **Equality between the regions be ensured;**
- **A catch-up budget plan be developed so as to raise the intensity of care given to individuals living in CHSLDs to an acceptable level.**

There is a broad consensus on the lack of home care and residential care resources for the elderly who have lost their autonomy. In some areas, very little home support services are available and in some CHSLDs, the response rate to needs, in terms of hours of care, is sometimes quite unacceptable for a society which values equity and compassion. Lastly, private residential resources are used while the mechanisms needed to assess the quality of the services that they provide do not always exist.

Lodging the elderly is a complex reality. The number of places in CHSLDs and other residential resources must be analyzed in the context of a continuum of services for the individual. It is humanly, clinically and economically unacceptable that 10 to 15 percent of acute hospital beds (including university hospitals) are occupied by the elderly waiting to be placed in institutional long-term care. It is unacceptable to use the hospital emergency or to extend the hospital length of stay of the elderly for social reasons or because of the lack of support services or residential resources. This lack of alternative resources as well as the lack of flexibility in admission to CHSLDs put more pressure on the hospital.

In this continuum of services, the network for the elderly who have lost their autonomy should be able to use, in collaboration with the individual and his family, the budget in a flexible way to ensure that all home support resources, public or private alternative residential resources and CHSLD resources are used in the most appropriate way. In exercising its clinical responsibility, the network must ensure the quality of care and services regardless of the place of residence or the type of accommodation.

As long as the capacity for home support services is increased and as long as more diverse and flexible alternative residential resources are developed, individuals admitted to CHSLDs will be those who have more severe disabilities and more acute medical and behavioural problems. The budget of the CHLSDs should be adjusted accordingly.

In brief, an increased and diversified provision of home support services and residential services is necessary. The goal must be better equality between the regions and sub-regions of Québec.

Lastly, the service-contract approach must be used to properly define the expected results and measure performance in terms of quantity and quality of services, regardless of whether the provision is public or private.

2.3.4.2 PERSONS AFFECTED BY SEVERE MENTAL HEALTH CONDITIONS

In 1989, the Government of Québec adopted a mental health policy which stated the need to adapt community-based services so as to better support individuals affected by severe mental disorders in their living environment. In the mid-1990s, the Auditor General of Québec noted that this policy was poorly implemented and few changes had been carried out.

In 1997, the Government of Québec adopted the *Orientations pour la transformation des services de santé mentale* (Orientations for reorganizing mental health services). This document mainly deals with services for individuals suffering from severe and persistent mental disorders, in other words, individuals affected by severe mental illness. It clearly stated the desire to bring the provider closer to the living environment, to diversify services and re-allocate resources on the basis of these choices. Courses and priorities of action were presented in this document.

In 1998, the Government of Québec introduced the *Plan d'action pour la transformation des services de santé mentale* (Plan of action to reorganize mental health services) in which empowerment as a collective and individual process was presented as a general principle. Two top priority clienteles were identified: adults with serious mental disorders, and children and youth with mental disorders. Eleven goals were presented with measurements and indicators for each of them.

In 1999, the Minister created the Support Group for the reorganization of mental health services, whose mandate was to support and facilitate change during the implementation of the Plan of action to reorganize mental health services.

In September 2000, during the Mental Health Forum in Trois-Rivières, the Minister announced her intention to consolidate basic provision in mental health and to give priority to child psychiatry and mental health services for children and adolescents. With regard to the individuals involved, the Minister emphasized the need to develop community-based follow up services, intervention services in a crisis situation, and support services to families and relatives as well as wider and more sustained access to medical treatments.

Currently, the views expressed by the many individuals and groups that we met are similar, that is, many intentions have been announced since the policy was published in 1989, but not enough actions have been taken.

According to "The World Health Report 1999"[18] published by the World Health Organisation, neuropsychiatric conditions account for 23 percent of DALYs (Disability-Adjusted Life Years) in high income countries in 1998, compared to 15 percent in 1990. Although less present among causes of death lists, "neuropsychiatric conditions are among the leading causes of disability and burden. Psychiatric disorders are frequently a considerable drain on health resources as a consequence of being misunderstood, misdiagnosed or improperly treated. With proper budgetary planning and allocation of resources, introducing an effective mental health programme into primary health care can reduce overall health costs. Mental health care, unlike many other areas of health, does not generally demand costly technology, rather, it requires the sensitive deployment of personnel trained in the use of relatively inexpensive drugs and psychological support skills on an outpatient basis."

"Mental Health: A Report of the Surgeon General," published by the Surgeon General of the United States in 1999, showed that about one in five Americans experiences a mental disorder in the course of a year, 9 percent have a mental disorder with functional impairment, 5.4 percent suffer from a severe mental health condition and 2.6 percent suffer from a severe and persistent mental disease. The Report stressed the following points: mental health conditions and mental illness affect people at all stages of their lives; a range of treatments of documented efficacy exists for most mental disorders; access to community-based services should be ensured by developing an integrated approach with the professionals and institutions concerned; there must be a sufficient supply of competent resources; and lastly, the stigma about mental illness must be overcome.

There are approximately 150,000 people suffering from severe and persistent mental disorders in Québec.[19] Schizophrenia, psychoses and other severe personality disorders are listed among these conditions. These individuals suffer from psychological distress and their level of disability has a marked effect on their personal relationships and basic social skills. Formerly, these people used to remain in psychiatric hospitals for long periods of time. Nowadays, as a result of de-institutionalization, they most often live in the community without being followed up by the appropriate resources.

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[18] World Health Report 1999, World Health Organisation, p. 16.

[19] Anne Gauthier (1998). *Organisation des services de santé mentale dans la communauté: enseignements à tirer de la recherche évaluative*. Ministère de la Santé et des Services sociaux, Collection Études et analyses.

Furthermore, the annual rate of suicide in Québec is 17.9 per 100,000 population, which is twice the rate in Ontario. Suicide has become the leading cause of mortality among men aged 15 to 39. The number of homeless people with severe mental illness, in addition to problems related to drug and alcohol consumption, is also increasing.

The Commission heard from several community rights advocacy groups calling for the "de-medicalization" of mental health conditions and for patients to take back their rights. The Commission also heard groups of mental health and psychiatry professionals denounce the fate reserved for people suffering from severe mental illness who have been de-institutionalized and are now on the streets without adequate resources while the majority of budgets, according to them, remain in the large psychiatric hospitals. Lastly, the Commission heard from the large psychiatric hospitals claiming leadership in the provision of services to people suffering from severe and persistent mental disorders.

It is clear that, beyond differences that are sometimes ideological, mental health conditions and mental illnesses are a very big problem and have a major impact on individuals, their families and the community. Many people are suffering as a consequence. Moreover, there are major problems of access to and continuity of care and services, as well as deep-rooted stigma. The Commission considers that responsibilities should be clarified rapidly and action should be taken.

BASIC SERVICES AND NETWORKS OF INTEGRATED SERVICES

P-23 For people with mental health conditions, we propose that

- **The basic mental health services be reinforced in CLSCs and the community network;**
- **On the regional board's initiative, networks of integrated services be created for people with severe and persistent mental disorders or affected by a severe mental illness;**
- **All these networks be under the responsibility of the institution which has the best experience and expertise to take on the leadership role.**

Unfortunately, the Commission has not had the time nor the expertise to analyze in depth the merits of the different visions that it heard.

In the previous sections of this chapter, we proposed a number of measures to help people with mental health conditions. They are as follows: basic mental health services, provision of psychosocial services for vulnerable clienteles in CLSCs, a clear role for the CLSC in the management of continuity of services with the *Family Medicine Groups*, other institutions and community organizations. The necessity of these measures is re-asserted in this proposal, which emphasizes the importance of the community network in the mental health field.

Moreover, the Commission deems that the model of an integrated services network for the elderly who have lost their autonomy, described above, should be tried with people affected by severe and persistent mental disorders. This model should follow the same guiding principles, to be adjusted on the basis of similar experiences in Québec, Canada and the United States. A team of professionals (psychiatrist, nurse, psychologist, social worker, occupational therapist, specialized educator, street educator) should be set up and affiliated with a "key institution" which would take on the leadership role in developing these networks. In each region or sub-region, the key institution should be the one which has the expertise and resources to best exercise this leadership. The mandate of the interdisciplinary team and the designated institution would be to provide or ensure that services are provided in the community where people live. The services are as follows: residential services, treatment services (mental and physical health), rehabilitation services, intensive and non-intensive clinical follow up, support for socio-occupational reintegration, and respite-relief services. Moreover, the expertise of community organizations should be resorted to, based on a subsidiarity approach, in order to allow people to live in their community for as long as possible. The regional board should initiate the establishment of these networks.

2.3.4.3 PERSONS SUFFERING FROM COMPLEX, OFTEN CHRONIC DISEASES

P-24 For persons suffering from complex, often chronic diseases, we propose that

Networks of integrated services be set up with a view to sharing knowledge and resources between the national, regional and local levels.

Diseases such as cancer, chronic obstructive pulmonary disease (COPD), heart failure, Alzheimer's disease, asthma and diabetes are progressive and often irreversible and have an increasingly dramatic impact on the functional abilities and quality of life of the individuals affected and their families. These diseases often require costly interventions and complex technologies in an interdisciplinary context. The clientele affected is growing and the treatment costs are generally high. It is therefore necessary to establish continuity of services and a more comprehensive approach to care, from primary care to tertiary care services. These diseases lend themselves well to the organizational form of a network of integrated services with, in general, a local, regional and national component.

These networks are often developed under the leadership of specialists in interdisciplinary medical and social teams, working in close collaboration with primary care teams. They are sometimes developed on the initiative of primary care physicians. Regardless of the initiator, it is essential that the *Family Medicine Groups* participate in them to ensure continuity of services for patients in their care. The network's coordinator can be a physician, a nurse or another health professional, chosen on the basis of the following vital criteria: leadership qualities, skills in clinical management and in coordination of interdisciplinary teams. The nurse clinician or nurse practitioner plays a key role in these teams.

This network brings together preventive, medical, pharmacological (disease management), social, psychological and rehabilitation interventions. The patient actively participates in managing his disease, which is called self-management of disease. The goal is to allow the patient to gain a better understanding of his condition, to manage his disease, to improve his quality of life and to use resources better. This type of network, many of which have already been set up in Québec, is highly successful. Thus, the Commission proposes that their number be increased and that their links with the organization of primary care services at the local level be developed.

Some of these networks of integrated services must be coordinated at the national level, through the MSSS or a central organization. In fact, certain types of disease such as cancer and heart diseases, require highly specialized teams, high-tech equipment and advanced research activities that cannot be dispersed throughout Québec. That is why it is necessary to have leadership, coordination and integration at the national level. The Commission's view is that there is no a priori contradiction between centralization and decentralization, that is, certain basic and specialized services must be decentralized to the nearest possible local level while activities that require a critical mass of patients and professionals, a rare expertise, highly specialized teams and leading-edge technology benefit from being grouped together, concentrated and coordinated at the national level.

Palliative care

Palliative care given to people in the final phase of their lives is a complex issue. These individuals who are suffering from a disease that progresses rapidly and is often unpredictable, the outcome of which is death within a relatively short period of time, are going through the biggest psychological and spiritual crises of their lives. They are surrounded by families and friends who are greatly distressed and who will remain so long after the person's death.

The number of deaths in Québec will soar in the coming years. The majority will result from a chronic disease, but currently, scarcely 10 percent of patients requiring palliative care actually receive it. Only 10 percent of cancer patients die at home. These figures are lower than those in the other Canadian provinces.

Adequate organization and financing must be ensured for all services to facilitate efficient and competent management of patients in the final phase of their lives at home, to increase their capacity to stay at home until they die, if they so wish. It is necessary to prepare families for bereavement. Hospital and CHSLD services must be adjusted, in particular by setting up palliative care units.

Individuals in the final phase of their lives and their families and friends need a complex combination of primary, secondary and tertiary care medical services, psychological, social, spiritual and support services. The palliative care networks are thus based on a linkage between the CLSCs and the *Family Medicine Groups*, and in particular, with the oncology hospital services. They must be able to coordinate these services, use the most relevant resources, have a capacity to respond and adjust rapidly, and to train providers.

Pharmaceutical services

Drugs are increasingly used as a therapeutic technology. Their effects are better targeted and secondary effects are in general better controlled. Moreover, the total cost of drugs is rising rapidly mainly because of the increase in volume and the intensity of treatment. Hence, there is a need to ensure optimal use of drugs through disease management tools and drug use reviews.

Although valid for health services as a whole, optimal drug use is particularly important for all networks of integrated care described above. It is all the more important because the patients cared for by these networks are often in transition between different health care settings: the home, emergency room, hospital, CLSC, rehabilitation centre, CHSLD, or temporary or alternative accommodation. This mobility requires vigilance, coordination and flexibility of pharmaceutical services. Thus, pharmacists must play an active role, representing pharmaceutical expertise in these networks.

2.3.5 COHERENT ORGANIZATION OF SPECIALIZED MEDICAL AND HOSPITAL SERVICES

R-7 We recommend that

The secondary care and tertiary care specialized medical and hospital services be consolidated on the basis of the following factors:

- **Hierarchical configuration of medical services;**
- **Reorganization of emergencies;**
- **Affiliation of specialist clinics with hospitals;**
- **Clarification of the university's mission.**

This recommendation is supported by 4 proposals.

The organization of secondary care and tertiary care medical and hospital services is the main concern of the general public, the media, professionals, trade unions, medical associations and the government. Just think of the ever-growing waiting lists, the overcrowded emergency rooms, the distribution of physicians, access to diagnostic tests and surgical procedures, the shortage of nurses and technicians in oncology, the referral of patients to the United States, hospital deficits and the role of university hospitals.

The Commission received numerous recommendations to improve the operation of secondary care and tertiary care medical and hospital services. Apart from an effective organization of primary care and a development of networks of integrated services, other more specific measures were also proposed. We have retained those which seemed to be the most likely to support the changes desired.

HIERARCHICAL CONFIGURATION OF MEDICAL SERVICES

P-25 With regard to the hierarchical configuration of services, we propose that

- **The MSSS and regional boards recognize the principle of the hierarchical configuration of medical services as one of the foundations of the Québec health care system;**
- **The regional boards decide about the role of local and regional hospitals and their services, and designate their respective territories;**
- **The MSSS, after consultation with the regional boards, define the role and services of supraregional hospitals and designate them;**
- **Hospital budgeting include financial incentives for both the hospital and clinical department heads to encourage the negotiation of formal contracts of service "corridors" between hospitals.**

The hierarchical configuration of medical services implies that the services are provided first according to the expertise of the physicians delivering the services. In other words, family physicians or general practitioners mainly practise primary care medicine and sometimes carry out some secondary care activities. Secondary and tertiary care specialists mainly provide specialized care, based on their expertise, but do not practise primary care medicine, except in rare cases.

The Conseil médical du Québec[20] (Québec Medical Council) defines the major characteristics of secondary care services as follows:

- Complex health conditions that cannot be solved at the primary care level;

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[20] Conseil médical du Québec (2000). *Propositions novatrices pour assurer l'accessibilité aux soins et la pertinence des services médicaux: Synthèse des avis du Conseil médical du Québec.*

- Infrastructure adapted to the hospital, rehabilitation centre, office or polyclinic;
- Complex but widespread diagnostic and therapeutic technologies;
- Specific and ad hoc type of services: consultation, further investigation, specialized treatments;
- Access to the specialist and return to the primary care level;
- Presence of basic specialties such as internal medicine, general surgery, anesthesia, psychiatry, etc.;
- Participation of general practitioners in hospital settings.

The characteristics of tertiary care medical services are as follows:

- Very complex and rare conditions;
- Field of highly specialized medicine;
- More advanced medical training than secondary care services;
- Highly qualified care teams and leading-edge technology technical support centres;
- Access to the specialist on request from the family physician or the secondary care specialist;
- Availability of these services at the national and supraregional levels and in a highly specialized hospital centre.

The levels of medical services should be set up to ensure optimal use of physicians' expertise, which is all the more important since there is a relative shortage of physicians in some specialties. It calls for a hierarchical configuration of hospitals, with service corridors and formal service contracts between these hospitals, which are negotiated with the respective clinical department heads. We propose that there be 3 types of hospital:

The local hospital

- The community or local hospital that serves one or a few regional county municipalities (RCM) or neighbourhoods. It includes general practitioners who practise in *Family Medicine Groups*, the CLSC and the hospital, and are supported by a team of physicians with the basic specialties in comprehensive general surgery, general internal medicine and anesthesia.
- It has an emergency department, acute care hospital beds, basic technical support centre (laboratories, basic medical imaging, operating area). This local hospital has very close links with the CLSC's primary care teams or the *Family Medicine Groups*.

- The hospital and its heads of departments or clinical services negotiate service corridors and formal contracts with a regional hospital or, in some cases, with a supraregional or university hospital, depending on the specialties.

The regional hospital

- Offers basic specialties and a few regional specialties or programs defined in collaboration with the regional board and the MSSS.
- Has a more developed technical support centre based on the recognized specialties.
- The regional hospital has a local mandate for all services and a regional mandate in certain specialties and programs. It is responsible for serving the local hospitals in these specialties through the defined service corridors.
- Under the supervision of the regional board, the regional hospital, through its heads of departments, or if applicable, its heads of clinical services, negotiates corridors of services and formal contracts with the local hospitals and, for some programs, with the *Family Medicine Groups* and CLSCs (e.g., heart failure network).
- Under the supervision of the regional board, the regional hospital, through its heads of departments, or if applicable, its heads of clinical services, negotiates corridors of services and formal contracts with the supraregional or university hospitals for the highly specialized services that are not available in the region.
- In certain regions such as Abitibi, the Gaspé Peninsula and the North Shore, the regional specialties or programs can be shared among sub-regional hospitals. It is first necessary to ensure a critical mass of staff and patients and a synergy between certain specialties (e.g., cardiology and pneumology). In these regions, it would be necessary to examine the possibility of first using specialists in internal medicine as secondary care medical specialists.

The supraregional or university hospital

- The supraregional or university hospital has a local and regional mandate for all specialized services and a supraregional or national mandate for certain highly specialized services.
- The expertise and equipment of these ultraspecialties are concentrated in a small number of hospitals because they require a critical mass of patients and professionals.

- This hospital has highly specialized staff and leading-edge technology in technical support centres.
- In addition, the university hospital has a teaching, research and evaluation mission. It evaluates the most recent technologies (equipment, drugs, procedures) as well as care practices and organization of services.
- The supraregional or university hospital, through its heads of departments, or if applicable, its heads of clinical services, negotiates corridors of services and formal contracts with the regional hospitals and, in some cases, with local hospitals, to provide highly specialized services.

The formal contracts for service corridors are negotiated between hospitals by the heads of department or clinical services under the supervision of the regional board. These contracts deal with, among other things, the procedures of consultation, the mechanisms for transferring patients, the transmission of information, returning the patient to the primary care level, family physician support, the "client" hospital's needs for services, the implementation of specific programs and continuing professional development.

A hospital can negotiate agreements with several hospitals in order to have access to various departments or clinical services. This flexibility allows for a degree of competition and the possibility of going elsewhere if one is not satisfied with the services. We recommend that hospital budgeting take these service contracts into account and that budget incentives be provided for hospitals and their department heads to conclude these agreements and that both partner-organizations be jointly evaluated on the results of these agreements.

2.3.6 REORGANIZATION OF EMERGENCY SERVICES

P-26 To reorganize emergency services, we propose

> **The rapid implementation of measures proposed in the *Projet Urgence 2000* (Emergency 2000 project) adopted in September 1999 and in the plan of action called *Relever ensemble le défi des urgences* (Let's take up the ER challenge) adopted in November 1999.**

It is necessary to change the dynamics of the use of ERs which have become, in practice, almost the only point of entry to the health care system and, often, the last resort. ERs should be reserved for urgent problems. It is our view that some recommendations constitute essential conditions for effective action upstream as well as downstream of emergency services, that is, the organization of a network of primary care services, networks of integrated services for the elderly who have lost their autonomy and for certain complex and often chronic diseases.

The *Projet Urgence 2000*[21] and the plan of action *Relever ensemble le défi des urgences*,[22] introduced by the Minister, were the results of a Forum on the situation in emergency rooms which brought together the principal players in Québec emergency services. The nine recommendations of the plan of action as they appear in the second document are as follows:

- Define and adopt a mission for ERs;
- Foster better coordination of care and services between hospital ERs, providers and services which are part of the network of community-based care, in particular CLSCs, CHSLDs, private clinics and other partners (through local agreements);
- Foster better continuity of care for vulnerable clienteles, in particular the elderly who have lost their autonomy and those affected by chronic diseases;
- Promote the case management of "major" clienteles and vulnerable persons by family physicians;
- Manage the effects of seasonal variations and increase of clientele;
- Foster the harmonious integration of emergency services into the hospital;
- Give ERs adequate access to the technical investigation support centre;
- Foster the involvement, stability and development of emergency staff;
- Establish a modern ER management method, based on the best models.[23]

In our opinion, there are two key measures among the other measures proposed in these documents.

- Implement a lump sum payment system for emergency physicians, in accordance with the mission of emergency services;

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[21] Ministère de la Santé et des Services sociaux (1999), *Projet Urgence 2000: de paratonnerre à plaque tournante.*

[22] Ministère de la Santé et des Services sociaux (1999), *Relever ensemble le défi des urgences: plan d'action.*

[23] Idem.

- Examine the possibility of developing the function of nurse practitioner in emergency care for, among other things, assessment and triage duties, in collaboration and complementarity with medical practice.

The Commission also considers that

- Access to residential resources, in CHSLDs or elsewhere, must be increased, made easier and more flexible.
- If the patient no longer has any medical reason to stay in hospital, the responsibility for taking charge of his case, including accommodation, should be transferred to the primary care team (CLSC and *Family Medicine Group*) or to the networks of integrated services if these networks are functional.

2.3.7 AFFILIATED SPECIALISTS' CLINICS

P-27 To improve flexibility in the provision of specialized services, we propose that

Specialists' offices or clinics be affiliated with a hospital and thus become the operational extension.

In a given territory, specialists practise medicine in a hospital or an office. Formerly, the hospital was the principal practice setting for the majority of specialists, especially surgeons. It is still true nowadays for several specialties. However, with the arrival of new technologies, certain diagnostic or therapeutic interventions which used to require a hospital environment can now be carried out in a more convivial and non-institutional setting. This is true of numerous interventions in ophthalmology, otorhinolaryngology and radiology. These interventions do not require the hospital's complex technical support centre nor its hostel services.

We therefore propose that specialists' offices be affiliated with a hospital centre and thus become an extension of its operation. Through this affiliation, the office's physicians are attached to a hospital clinical department (e.g., internal medicine, cardiology, general surgery, radiology). They are accountable to the same department head and must comply with the standards of practice and participate in the hospital's council of physicians, dentists and pharmacists (CMDP). *Group* practice is encouraged and highly valued at the expense of those who practise on their own. In this way, all the specialists of the same department, regardless of whether they work in a hospital or an office, can provide all the medical activities required in the specialty.

The affiliated office exists where needs – in terms of clienteles and activities – justify its existence. An office is affiliated under an agreement in which the physicians involved, the hospital (through its clinical department head) and the regional board take part. This agreement defines the parties' mutual obligations, that is, the supply of services, the resources agreed to, the results expected and the methods of accountability. The management of resources of the affiliated office is under the sole responsibility of the physicians who work there under the agreement.

In this context of an extension of the hospital clinical service, the affiliated offices could provide, based on an agreement with the hospital and under the clinical supervision of the clinical department head involved, specialized medical services that are currently delivered at the hospital, such as some outpatient clinic activities, certain diagnostic tests (e.g., medical imaging), some minor surgeries or day surgeries. The goal here is to continue to encourage the shift towards an ambulatory care setting of diagnostic or therapeutic activities which, owing to technological progress, no longer require the complex hospital organization and can be carried out in a day. This is based on the principle that a diagnostic or therapeutic intervention which is deemed medically necessary, must be ensured independently of the delivery setting, whether in the hospital or an office.

The affiliation of specialists' offices and clinics with a hospital, attached to the head of the clinical department or service should make it possible to

- Improve patients' access to services;
- Reduce waiting lists;
- Better distribute medical activities within a specialty and increase the sinergy between specialists;
- Gradually relieve congestion in the operating area and, indirectly, the ER.

The framework for the affiliation of physicians' offices should be based on the following principles:

- The patient does not have to pay any more or any less than if the intervention was carried out in the hospital;
- The head of the department or service and the CMDP of the hospital evaluate the quality of services;
- There must be financial and operational advantages for the hospital and the health care system;
- The affiliation must not deprive the hospital of the medical availability of physicians in affiliated offices;
- The affiliated offices and their physician-members bill the RAMQ and cannot bill the patients over and above this. A physician cannot practise in both an affiliated office and an entirely private clinic outside the RAMQ.

Services therefore continue to be publicly funded and physicians are paid by the RAMQ. The operating costs, including the depreciation of technical equipment, will be pre-negotiated between the hospital and the affiliated office. The duration of the contract will take into account an optimal depreciation period and the useful life of the equipment, if applicable. The contract will outline the mechanisms for evaluating results, the parties' mutual obligations, and the usual safeguard clauses. The regional board determines the number of these clinics in its region and, in collaboration with the hospital and the department head involved, evaluates the quality of services.

Given that this recommendation is quite innovative, we propose that it be implemented gradually through implementation projects, with continuous evaluation of results.

2.3.8 CLARIFICATION OF THE MISSION AND THE ORGANIZATION OF UNIVERSITY HOSPITALS

The current situation of university hospitals is rather confusing. There are university hospital centres (CHUs) which should normally offer all or almost all the major teaching programs in medical specialties. There are also affiliated hospital centres (CHAs) which should offer some teaching and research programs to complement those of the CHUs; and, lastly, there are institutes which, in general, offer only one teaching and research program in one specialty. In reality, there is no clear distinction between CHUs, CHAs and institutes. For example, a number of major programs are not offered in CHUs but in CHAs. This confusion creates competition between these three types of institution with a teaching vocation which, in our view, is unhealthy and costly. There are also problems inherent to the process of merging CHUs.

The Commission has the impression that what is being implemented in Québec does not correspond to the concept of a CHU, which exists elsewhere in the world. The process of designating and grouping together university hospitals has been more influenced by corporate and political interests, unhealthy rivalries and petty quarrels rather than by the public interest of offering excellent quality of care, teaching and research. The situation is still worrying today as billions of dollars are about to be injected into the construction of two new CHUs.

As regards budgeting, the components of teaching, research, evaluation and introduction of new technologies (including new drugs) as well as the component of supraregional and national services, are not clearly defined and, consequently, are not recognized for their specificity. University hospitals have what are called nominal budgets, they consistently have deficits, except in a few rare cases, that the MSSS ends up covering without addressing the source of the recurrent problem. These recurring deficits are detrimental to the credibility of university hospitals since it is almost impossible to determine which part is structural, therefore university-related, and which could be reduced through better management.

With regard to payment of physicians, the mixed system offers some possibilities for improving remuneration for teaching, research and evaluation. However, we are still very far from the practice plans of some Canadian and American university hospitals. These CHUs outside Québec have teaching and research objectives that are clearly and jointly set by the faculty of medicine and the hospital, with financial incentives for academic productivity and mechanisms of continuous evaluation. In these CHUs, the head of the clinical department is usually also the head of the teaching department and he negotiates the distribution of tasks and remuneration with the physicians in his department.

The situation of medical staff is precarious in certain specialties of university hospitals, which threatens clinical, teaching and research programs. It thus seems that any examination of the future of university hospitals must consider possible collaboration not only between hospitals but also between faculties of medicine and universities. With a population of 7 million, Québec cannot afford to live indefinitely with this situation, where faculties of medicine and university hospitals, all in a precarious situation, compete with each other for the same scarce resources. There is a high risk of balkanization if these resources, which are vital for the development of teaching and research, continue to be scattered.

With regard to management, there is a triple accountability which is, moreover, poorly defined. University hospitals are accountable to the regional board for the services they provide to the population in their region. University activities are not included in the mandate of the regional board and the accountability is not clear with regard to the supraregional services provided by these hospitals. University hospitals are accountable to the MSSS for teaching, research and technology evaluation activities, and a number of national ultraspecialties. However, the MEQ and the universities play a vital role in teaching and research. Through health research development, the Ministère de la Recherche, de la Science et des Technologies (MRST) and its Fonds de la recherche en santé du Québec (FRSQ, Québec health research fund) are also among the major players that have an influence on the development of these hospitals. Two hypotheses were submitted to the Commission, that is, either the CHUs come directly under the MSSS's authority or they remain attached to the regional boards. The Commission's view is that, in a context of integration of primary, secondary and tertiary care services, it would be inappropriate for the CHUs to be entirely accountable to the MSSS. Moreover, it is essential that the MSSS and its partners establish the orientations, priorities and funding (operation, assets and equipment) or national specialized services and the university mission of teaching, research and evaluation.

Lastly, health research is on the point of making major breakthroughs in the field of fundamental, clinical and epidemiological research, and in technology evaluation, care practices and service organization. Research is crucial for the development of new knowledge and its application to clinical and organizational fields. The FRSQ and the new Canadian Institutes of Health Research (CIHR) have announced substantial investments. They are promoting the creation of pan-Canadian and international multiple-centre research on specific themes with interdisciplinary teams. Consequently, research centres of university hospitals will have to be better organized, better targeted, and will have to be structured as inter-hospital and inter-university networks. Moreover, this emphasis on speeding up research development pointedly raises issues related to research ethics, intellectual property rights with regard to discoveries and their application, marketing and role in Québec's economic development as well as the links with the health industries.

The Commission deems that it is urgent to act in order to clarify the academic mission of hospitals, stabilize their development and funding. A ten-year mobilization project must be drawn up in order to restore hope and pride to the clinical, teaching and research staff. A modern vision of a network of university hospitals should be adopted very soon, drawing on the experiences in the rest of Canada, the United States and Europe. Only then can Québec hope to rank among the leaders in the field of teaching, research and technology evaluation.

Given the major challenges involving various departments, this mobilization project must come from the highest level.

P-28 To adopt a modern vision of a network of university hospitals, we propose that

- **An interministerial committee be created and composed of the ministers of Health and Social Services, Education and Research, Science and Technology, and be accountable to the Executive Council;**
- **This committee include experts from Québec and elsewhere in the world;**
- **This committee have the mandate to propose, in 6 months, a modern vision, for a 10-year period, of the organization of a university network (clinical, teaching, research and evaluation) in the field of health, and recommend the means to achieve it.**

The following factors could be examined:

- Re-evaluate the notions of CHU, CHA and university institute and clarify their role, if applicable, from the perspective of complementarity and scarcity of resources;
- Propose the location of ultraspecialties, research centres and institutes, and teaching programs, taking into account the need to concentrate "research and development" activities on the basis of the critical mass required by this type of resources;
- Determine the contribution of teaching, research and evaluation activities of university hospitals to Québec's social and economic development;

- Take into account the recommendations made by the Comité sur la réévaluation du mode de budgétisation des établissements (Committee to re-evaluate the budgeting methods of institutions) chaired by Mr. Denis Bédard, and determine the level and methods of funding and budgeting for teaching, research and technology evaluation activities and supraregional services as well as the overall impact of these activities on the rest of the institution's operations;
- Define the responsibilities, mechanisms and methods of accountability of university hospitals in relation to their mission of providing local and regional care, supraregional care, as well as teaching, research and evaluation;
- Assess the contribution of other types of institutions and integrated networks (e.g., *Family Medicine Groups*-CLSCs, networks for the elderly populations, for people with complex diseases) to the university mission of teaching, research and evaluation.

2.3.9 MORE RESPONSIBILITIES AND GREATER ACCOUNTABILITY FOR PHYSICIANS AND NURSES

R-8 We recommend that

> **Physicians and nurses participate more actively in the organization of care delivery and management, more specifically in the hospital.**

This recommendation is supported by 4 proposals.

Physicians are not employees of the hospital as defined in the Labour Code. However, their activities form the very basis of what a hospital is. The principal duty of physicians is to treat patients and, in practice, their diagnostic and therapeutic decisions for patients give rise to a large part of the hospital's activities. Physicians do not feel very involved in care management activities even though these activities are the very "heart" of hospital activities. They have the impression of being outside the "network." Hospital managers are also of the same opinion. This gap between the function of "production of medical care" and the function of "management of this production" is a complex issue, especially in relation to the challenges to be taken up.

Nurses, on the other hand, are employees of the hospital. However, they also feel restricted in their professional involvement. Other types of staff with less training could carry out many of the acts performed by nurses, at a lower cost and achieving a similar quality. Moreover, nurses would like to see their role and practice broadened to include more clinical responsibilities and flexibility in the redefinition of care processes. They consider that they can play a much more relevant and useful role in the delivery of complex care, both in primary and tertiary care.

The hospital of the future will be an environment of increasingly complex specialized services that require interdisciplinary work, differentiated care practices, links with primary care teams and highly specialized teams, continuous technological and pharmacological developments, sophisticated equipment, different budgeting methods, and increased evaluation of results. This complex environment, which is constantly changing, requires that physicians and nurses become stakeholders, participate actively, agree to review the specific contribution of everyone in their profession and be paid accordingly.

We propose 4 measures to enhance the participation of physicians and nurses:

- A mutual commitment on the part of the physician and the hospital based on a service contract;
- A payment system for physicians that is adjusted to the various tasks to be performed;
- Greater role and adequate payment for the head of the clinical department;
- Enrichment of the role of nurses, increased training and gradual integration of nurse practitioners.

2.3.9.1 A PHYSICIAN-HOSPITAL SERVICE CONTRACT

P-29 We propose that

A contract be signed between the physician and the head of his clinical department or service, thus formalizing the physician's appointment to the hospital by the board of directors.

This contract should specify, among other things:

- The status and privileges granted to the physician;
- The responsibilities and the local and, if applicable, regional clinical tasks;

- The responsibilities and teaching and research tasks, if applicable;
- The responsibilities and clinical management tasks, for example, coordination of specific programs, development of protocols, participation in medical and hospital committees;
- The payment systems for these various activities, including teaching and research;
- The expected results and methods of evaluating these results;
- The hospital's commitments, for example, work tools, secretarial support services, technological support, and access to information.

This contract would take into account the respective responsibilities of the director of professional services (DSP) and of the council of physicians, dentists and pharmacists (CMDP) within the institution.

2.3.9.2 MIXED PAYMENT SYSTEM FOR SPECIALISTS

P-30 We propose that

Specialists be paid according to the mixed payment system, based on the tasks that they must perform, as defined with the head of their clinical service or department.

The activities of specialists are highly diversified. They deliver specialized or highly specialized care, often within an interdisciplinary team, then refer patients to the primary or secondary care physician. They act as consultants to primary or secondary care physicians and provide professional support to the network of primary care services, that is, case discussion, care protocols, continuous training. They collaborate in training students and residents. They also collaborate in research and participate in evaluation projects. Lastly, they act as managers of specific programs, participate in medical and administrative activities, and evaluate their practices. All these activities, which are necessary for the smooth operation of our medical hospital services, must be compensated.

The concept of mixed payment (hourly rate, lump sum, fee-for-service, salary) already exists and must be developed. These payment systems must be linked to the medical activities that are required in the hospitals' clinical departments and services and in the affiliated offices. The head of department or service must be responsible for negotiating with each physician in his department or service, the distribution of activities and their type of payment, taking into account all the required medical activities. The payment of physicians of affiliated offices should be higher than that of physicians of non-affiliated offices. This way of compensating specialists should allow them to concentrate on the activities related to their specialty and to be gradually released from primary care activities.

2.3.9.3 ENRICHED ROLE AND ADEQUATE REMUNERATION FOR THE CLINICAL DEPARTMENT HEAD

P-31 To improve the hospital's medical-administrative management, we propose that

The clinical department head be entrusted with a greater role, a clear mandate, and be adequately remunerated.

In today and tomorrow's hospital, the head of the clinical department must play a decisive role in the hospital's clinical and administrative management. In collaboration with the heads of services and the physicians in his department, the head of the clinical department must define and distribute among the members, the following 3 types of activity:

- The clinical activities required in his department (including the activities of affiliated offices, the regional activities, support activities for primary care);
- Teaching, research and evaluation activities, if applicable;
- Clinical, medical-administrative management activities.

He must assume the clinical and financial responsibility of his department's medical activities. He must be remunerated at a competitive rate in order to perform his management duties. The hospital must provide him with human, financial and technical resources to carry out his mandate.

In such a context, in terms of the organization and management of his department, the department head is accountable to senior management via the director of professional services. He is a member of the hospital's management team. He signs a contract with the hospital management which specifies the obligations and payment mechanisms. This proposal could also apply to certain clinical service heads. Where the physician assumes the role of director of the care program, this management responsibility must also be defined and remunerated.

Lastly, with regard to the overall management of care, it is essential that the heads of clinical departments and services cooperate closely with the head nurses as well as with other professionals and the entire staff in his sector of activity.

2.3.9.4 ENRICHMENT OF NURSES' ROLE, INCREASED TRAINING AND INTEGRATION OF NURSE PRACTITIONERS

P-32 To improve flexibility in the organization of care, we propose that

- **The role of nurses practising in hospital and elsewhere in the network be enriched;**
- **Nurse practitioners be trained and gradually integrated through implementation projects.**

It was stated above that some of the tasks that nurses currently perform could be assigned to nursing assistants, hospital attendants or support staff, who would provide similar quality at a lower cost. The Commission believes that the allocation of roles and tasks in the field of nursing care should be re-evaluated from the perspective of a global vision.

Such an allocation would allow nurses to concentrate on activities related to their training, expertise and experience. They could ensure systematic follow up of the clientele in the hospital, CLSCs, *Family Medicine Groups* and integrated care networks. They are often the best trained and the most experienced people to coordinate follow up using an interdisciplinary approach.

They should also take on a greater role in health education in childcare centres, schools, CLSCs, *Family Medicine Groups* and Info-Santé. They could play a greater role in the hospital or in an outpatient centre by preparing patients to manage their diseases. Nurse clinicians who have an expertise in some more specialized fields, in regional hospitals or specialized hospitals, could, through service agreements, provide support to the CLSC's home care nurses or less specialized hospital nurses.

The function of nurse practitioner has been in existence in the United States for many years. These nurses, who practise in all the states, are subject to the *Nurse Practice Act* of each state. This function is characterized by more advanced studies and clinical training in a specialized field (e.g., oncology, emergency, primary care, psychiatry, neonatalogy, geriatrics). In addition to the usual nursing work, nurse practitioners can, in accordance with the legislation of their state, take the patient's medical history, conduct a physical examination and provide a number of diagnoses and treatments for specific situations as well as prescribe certain tests and drugs.

In Canada, the regulation allowing nurses to perform advanced practice acts in specific circumstances exists in Ontario and Alberta but not in Québec. A few months ago, the Minister of Justice, who is responsible for the application of the Professional Code, launched a consultation process on amendments to be made in order to adapt current laws and regulations to changes in professional practices and care organization.[24] The Collège des médecins du Québec (Québec college of physicians) has indicated that it is open to the re-examination of the professional system.

> "...*the College believes that certain types of care can be given by health professionals other than physicians, for reasons of availability, effectiveness or efficiency, thus releasing the physician for other high priority activities where he cannot be replaced.*
>
> *However, to foster the adjustment of the professional system of public protection to current and future realities, and to foster the complementarity of professionals and their cohesion, a re-examination of the professional system in the field of health must be initiated.*"[25] (translation)

The Ordre des infirmières et infirmiers du Québec (Québec college of nurses) is also calling for this modernization. Physicians and nurses at the local level are setting up or about to set up projects to enrich the role of nurses in neonatalogy, surgical assistance, nephrology and walk-in clinics.

The nurse practitioner will be able to play a key role in the organization of primary care services in CLSCs and *Family Medicine Groups*. She will work in collaboration and complementarity with family physicians. In this context, she will be able to take charge of clienteles with common health problems. She will carry out prevention and health promotion activities, clinical screening activities, certain diagnoses and treatments as agreed with the group of physicians, activities of systematic follow up of clientele, including liaison activities with the CLSC and secondary care services.

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[24] *La mise à jour du systeme professionnel québecois*, Plan of action presented by Linda Goupil, Minister responsible for the application of professional laws, February 2000.

[25] Collège des médecins du Québec (2000), *Organisation des services médicaux*, p. 8.

The Commission thus proposes that the regulation on the health care professions be amended rapidly to allow for the creation of an adequate legal and professional framework for advanced nursing practice in some specialized areas. At the same time, demonstration projects in some specific areas could be implemented, based on needs expressed locally, in collaboration with the professional bodies involved and with the support of the MSSS.

2.3.10 MEASURES TO FACILITATE A BETTER DISTRIBUTION OF PHYSICIANS

R-9 We recommend that

- **The MSSS reassert the importance of the physician as an essential partner in the delivery and organization of health services;**
- **It ensure that the organization of services be set up to facilitate the recruitment and retention of physicians, including the proposals in this report;**
- **It rapidly reach a consensus on the situation of medical human resources in Québec and develop a continuous and integrated medical staffing plan, in terms of general practitioners and specialists, promoting risk management rather than crisis management;**
- **It amend the law so as to better ensure the link between the physician's responsibility and accountability for the services that he provides to the population;**
- **The regional boards have the legal power to enter into joint agreements with the MSSS and medical associations, and have at their disposal a specific budget allowance (outside the payment agreements) to help solve the problems of recruiting, retaining and assigning medical staff;**
- **The MSSS and regional boards produce a report on the results of the distribution measures proposed one year from now and every year thereafter.**

There are certainly problems of access to medical services. For primary care services, there are problems in the cities as well as in the regions, although they are quite different.

A citizen who is looking for a family physician in Montréal or in Ville-Marie will have a lot of trouble finding one. There are also problems of access to specialized and highly specialized services, either because they are geographically too remote or because the waiting period is too long. Waiting lists are often long and some more vulnerable clienteles have trouble gaining access to the required medical services, for example, the elderly who have lost their autonomy or those affected by severe mental health problems.

This situation can sometimes be acute and develop into a crisis: ER overcrowding, closing down of an ER or a specialized program, threats to resign, actual resignations, long waiting lists, transfer of patients from the regions to urban centres or, in some cases, to the United States.

Criticisms are levelled at physicians, the Minister, the government, the regional boards and managers. In the regions, people are taking action and, having deemed that the incentive measures have failed, are calling for the regionalization of the RAMQ envelope and a law "with some teeth" to force physicians to practise in the regions. People are both angry and insecure about the medical shortage. Rapid results are being demanded and the government is being asked to adopt measures to coerce physicians into practising their profession where the population's needs call for it.

The Commission heard many points of view about the number of physicians, their accessibility, and their distribution, especially in the regions. Are there too many, enough or not enough physicians in Québec? Or is it just a question of distribution or organization? Any answer must be qualified by many factors. There is, of course, the absolute number of general practitioners and specialists to be considered, but there are also the factors of age, sector-based distribution, the style of practice resulting from the payment system and the type of working life that physicians wish to have. Lastly, the feminization of the profession, the change in profiles of service consumption, the training, needs, the sharing of fields of practice and many other considerations should be taken into account. The Commission did not have the time to examine all these factors.

There is nonetheless a real shortage of physicians in certain regions, in certain types of institution, for example CHSLDs, in certain specialties and in certain activities or programs. In many regions, physicians are leaving and others are threatening to do so. It is difficult to recruit them and just as difficult to retain them. In certain areas, stopgap medicine has become the norm. The shortage is felt in peripheral and remote regions, but in certain specialties, the shortage is also felt in central regions.

We also heard from groups of physicians who told us that they felt powerless and demotivated with regard to this situation. They told us about a growing demand for services in a context of difficult access to secondary and tertiary care consultation, diagnosis and treatment resources. They told us about the problems of working on their own or in small groups in the regions without the support of more specialized hospital colleagues, in a context where primary care is not organized. They are concerned about the ageing of the profession and the mass buyout of physicians and nurses in recent years. They lack the means to practise the kind of medicine for which they were trained and that payment on a fee-for-service basis does not encourage case management and systematic follow up of their patients. They feel that they are perceived as the "bad guys" who are blamed when things go wrong, but who are hardly consulted in the process of staff planning or organizing services. Physicians and other professionals have been profoundly affected by the recent changes in the health network. Over the last 10 years, 20 percent of requests for help were made during the year 1999-2000 alone and 70 percent of these concerned psychological distress.[26]

In the Commission's view, the problem is complex and its nature differs in all Québec regions. There is no single, magic, instant solution. Nevertheless, several regions have organized services so as to facilitate the recruitment and retention of physicians, for example, in Magdalen Islands and Saint-Pierre Harbour. We believe that it is important to acknowledge and draw on the experiences that have been a success and to learn from our failures. We prefer a positive approach based on incentive instead of a coercive approach. We favour contractual agreements which clearly establish mutual responsibilities and accountability instead of a legislative or regulatory approach. We also believe that preventive management of risks must be developed instead of relying on crisis management.

The Commission considers that the problems originate from

- Lack of organization of services;
- Lack of knowledge about the actual staff situation;

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[26] **Collège des médecins du Québec.**

- Poor staff planning;
- Payment systems that do not encourage management of patients;
- Lack of physician accountability, individually and collectively, for the services to be provided to a population.

We suggest an approach that has 5 components:

- Re-assert the physician's role as an essential partner in the health care system;
- Implement an organization of services that facilitates a stimulating medical practice;
- Review the financial incentives based on the experience over the last 10 years;
- Learn about the staff situation at the regional and national levels and subsequently plan in a continuous way;
- Make a number of amendments to the law.

2.3.10.1 RE-ASSERTING THE PHYSICIAN'S ROLE

We propose that the MSSS and medical associations mobilize members of the profession in a positive way by re-asserting the essential role of the physician, that is, a professional who has a privileged relationship with his patients, based on professional autonomy, and is an active partner in the organization of health services. There is also a need to affirm the responsibility of the physician and the accountability of the medical profession with regard to the population and to emphasize the fact that physicians must be part of the solution. In addition, the Commission proposes measures to increase physicians' participation in the decisions concerning them:

- Participation of physicians in the board of directors;
- Greater role, adequately compensated, for the clinical department head;
- Possibility of offices affiliated with the hospital;
- Primary care services based upon *Family Medicine Groups* and CLSCs as the foundation of the health care system.

2.3.10.2 AN ORGANIZATION OF SERVICES THAT MAKES MEDICAL PRACTICE ATTRACTIVE AND STIMULATING

An organization of services that makes medical practice more stimulating should be implemented, including group practice, an interdisciplinary approach, formal functional links with colleagues who are general practitioners or specialists, access to consultation and an adequate technical support centre. In our view, several of these recommendations would help solve the organizational aspect of physician distribution:

- A hierarchical configuration of medical services;
- A hierarchical configuration of hospitals;
- Service corridors through service contracts;
- Organization of primary care services based on *Family Medicine Groups* and CLSCs;
- Collaboration of nurse clinicians and nurse practitioners;
- Greater physician responsibility and accountability through agreements that lay down the results expected from medical activities;
- Responsibility of the regional board's DRMG in the implementation of primary care medical organization;
- Regional responsibility of a clinical department head of a regional hospital;
- Possibility of clinics affiliated with the hospital department or service.

2.3.10.3 REVIEW OF FINANCIAL INCENTIVES

The Commission consulted several individuals and groups on the feasibility of regionalizing the RAMQ budget allowance and linking it with physicians' remuneration. Although theoretically an attractive idea and desirable in the long-term, it is hard to put this hypothesis into practice. Even several of those who had called for this regionalization, recognized that this would not solve the problem and would be very hard to administer. We thus focused on the two following proposals for financial incentives:

- Mixed payment system linked to the targeted goals of distribution of medical activities, that is under the DRMG's authority in the case of general practitioners and under the clinical department heads' authority in the case of specialists;

- Grant a specific budget allowance to regional boards, outside remuneration agreements, to help solve the problems of recruiting, retaining and assigning staff.

2.3.10.4 MEDICAL STAFF PLANNING

First, a portrait of the real situation of medical staff in Québec, including general practitioners and specialists, must be drawn and kept up to date. At the same time, it is necessary to have adequate tools to plan medical staffing in a continuous way. We propose that

- The MSSS actively work with the Table de concertation permanente de planification de l'effectif médical (Round table on medical staff planning) in Québec in order to rapidly reach a consensus on the situation of medical staff;
- Flexible staff planning take account of our recommendations on primary care organization and the hierarchical configuration of medical services;
- The DRMGs and the regional medical commissions of the regional boards collaborate with the medical associations to plan their staff at the local and regional levels, taking into account the planning at the national level;
- At the regional and national levels, there should be a mechanism for continuous staff management that includes the management of general practitioners and specialists and fosters risk management instead of crisis management ;
- The accountability of the various players and the main rules of the game in the implementation of the staffing plan be clearly defined;
- The MSSS and the associations adopt an emergency measures plan to intervene anywhere should a major problem arise.

In the short-term, a number of targeted and exceptional measures would allow for the increase in the number of medical staff if there is a real shortage:

- More openness to and flexibility in recruiting physicians trained in Canada and the United States or already having a right to practise in other provinces, with a status recognized by the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada;

- More openness to and flexibility in recruiting physicians trained in other countries to compensate for acute shortages in an area or a specialty, while complying with the criteria of quality and excellence laid down by the Collège des médecins (Québec college of physicians);
- Increase the number of resident places for residents coming from other provinces or the United States in order to maintain services or training programs in some specialties in the universities.

2.3.10.5 AMENDMENTS TO THE LAW

The state, as an insurer and payer, must foster the establishment, in collaboration with the regional boards and health institutions, of attractive conditions for practising medicine throughout Québec. In return, it must ensure that physicians are accountable to it for the services that they provide to the population. The Commission deems that a number of legislative amendments are needed to support the regional medical staffing plans. For example, an amendment to the section in the law allowing a physician to cease to practise medicine must be envisaged. This section must not be used by physicians as a means of collective pressure. Moreover, it is necessary to examine whether or not it is relevant to extend the current time period of 60 days' prior notice that a physician must give when deciding to end practice. This would provide the time needed to find solutions and avoid any break in services. The legislative review should allow the regional boards to act prior to any request for privileges made by a physician to an institution and ensure that this request is eligible for examination by an institution, that is, that it is consistent with the regional medical staffing plan. Lastly, the law should be amended to facilitate the exchange of data between the regional boards and the RAMQ so that the latter can cease to pay any physician who is practising in an institution in a way that is not consistent with the medical staffing plan and so that the institution can also be subject to a penalty.

We believe that by implementing our recommendations, the MSSS, in collaboration with the medical associations, the Collège des médecins, the regional boards and institutions, will be able to find a fair solution to the distribution of physicians and to ensure the population access to the health services guaranteed by the law. It is also our view that local, regional and national managers must play a strong leadership role and adopt a proactive management style so that they can see a crisis coming rather than simply waiting for it to happen.

To conclude, the Commission is concerned about the way the relationship between the population, in particular in the regions, and the medical profession as a whole is evolving. Throughout our deliberations, it was perceived that individuals and groups have respect for and confidence in the professional and clinical responsibility of physicians and the way they exercise it.

Nevertheless, these same individuals and groups were often highly critical of the way the Québec medical profession exercises its collective responsibility for services to the population. It is certainly hoped that the social and political tensions between such important professionals and the regional populations do not lead to confrontations in which the government has to arbitrate. Let's hope that leaders of the medical associations and regional boards will soon adopt the measures advocated in this report with the same willingness and openness that they have demonstrated throughout our deliberations.

2.3.11 EFFECTIVE AND SECURE CLINICAL AND MANAGEMENT INFORMATION SYSTEMS

R-10 We recommend that

Effective and secure clinical and management information systems be implemented.

Currently, it can be maintained that the health and social services sector has become dependent on the ability of the various intervening parties to gain access to information and knowledge and exchange them. Clinically, the physician as well as the nurse and social worker need to collect information on the patient's health status and social condition. Requests for care and services are more complicated and diseases are more and more chronic. Care episodes and follow up require the participation of numerous intervening parties, all in different settings that are sometimes far from each other.

Yet, the overwhelming majority of participants in the Commission's hearings deplored the poor quality of our clinical information systems. Thus, it is very hard to obtain reliable health and social data on the population. They all emphasized the need to have effective and secure clinical information systems. This is one of the conditions for a true integration of the network of services and for the implementation of a population-based approach.

With regard to management, the network has financial, medical and administrative data. However, these data are incomplete and they are neither interrelated nor do they reflect the new reality of ambulatory care. Therefore, it is impossible to make useful correlations between the clinical, operational and financial data of institutions and organizations in the network. Thus, it is almost impossible to know the real costs of care episodes in the hospital or the cost and bebefits of CLSC programs.

Nowadays, major breakthroughs are achieved in information and telecommunication technologies, and all economic sectors are benefiting greatly from this. Despite efforts made in recent years, the health sector still lags behind considerably. Apart from the creation of the health and social services telecommunications network (RTTS), experiences in telemedicine, and the development of a number of applications, little progress has been made at the centre of medical and hospital operations. One in two health institutions still does not have clinical information systems in its laboratory, radiology, pharmacy and nursing care. Physicians' offices are not linked to the RTSS and the shared computerized health record does not really exist. Thus, with the shift to ambulatory care, the patient moves around but the information does not follow him.

The Commission is aware of the high costs that such a catch-up would impose. This issue will be dealt with in Chapter 4. It is also aware of the capital importance of data confidentiality, patient's consent, and the security of data exchanges. However, it deems that an enterprise whose annual expenses total more than $16 billion does not have the choice. It must invest in order to provide

- Citizens with information so that they can better manage their health and make better choices;
- Its professionals with clinical decision support systems;
- Its managers with management decision support systems;
- Its analysts and researchers with analysis and evaluation tools.

Moreover, this must be done with respect for the patient's consent, the confidentiality of personalized data and the security of information exchanges within the network.

In brief, without clinical and management information systems that are reliable and can be shared, services cannot be truly integrated.

ANNEX 1

GLOSSARY OF TERMS

A few definitions of the commonly used terms are suggested to facilitate understanding of this chapter.

"Medically required" service

A "medically required" service is a service that is related to the prevention of disease, the diagnosis or treatment of disease, injuries and traumas and the resulting disabilities; a service that meets medical standards; a service that is delivered either on an individual basis or to a population in the public health framework.

Hierarchical configuration of services

There are three different ways to define the hierarchical configuration of services. 1) The primary care, secondary care and tertiary care services refer to the organization of the health care and social services system and the patient's movement through the system. 2) Primary, secondary and tertiary care represent the level of care required by users. 3) Lastly, general, specialized and highly specialized care refer to the level of care provided by the professionals.

Primary care services

As a point of entry to the health care system, primary care services are the population's point of contact with the health and social services network.

These include basic medical and social services which rely on a light infrastructure of diagnostic and therapeutic means to solve the majority of common social and medical concerns and problems of the population.

Secondary care services

Both social and medical secondary care services help solve complex problems. They include services of assistance, support, lodging and a set of specialized services which rely on an adapted infrastructure, and for medical services, a heavy but widely used diagnostic and therapeutic technology.

Tertiary care services

A highly specialized level of medicine, the tertiary care services are intended for individuals with highly complex health conditions, or conditions whose occurrence is very low (concept of rarity).

Practice in a field of expertise

The practice of an experienced nurse in a recognized specialized field. The nurse has acquired knowledge (formally or informally) and the technical and relational skills specific to the clinical area.

Advanced practice

Practice that includes a high level of autonomy, independence and accountability which requires that the nurse master skills and an advanced level of theoretical and practical knowledge as well as the basic skills and knowledge in clinical research. This will allow her to function within the full scope of nursing practice and, in certain cases, to perform some diagnosis and treatment activities that are normally reserved for physicians.

Nurse clinician

The nurse clinician functions as a specialist in a field of clinical practice. Her leadership is expressed through the major components of her role, that is, the provision of direct care or in acting as a role model, teaching, designing and developing programs, clinical processing that is useful to the coordination of clientele follow up, clinical research, consultation, referral and close collaboration with the interdisciplinary team.

The nurse clinician has acquired additional nursing education with a clinical orientation.

Nurse practitioner

The nurse practitioner performs a role which is similar to that of the nurse clinician in a field of clinical practice but is characterized by the therapeutic management of the client, working in close collaboration with the physician and the interdisciplinary team.

She possesses advanced knowledge and skills that she applies in particular to the field of clinical evaluation, diagnosis and treatment of clients with different health conditions.

The nurse practitioner has acquired additional nursing education with a clinical orientation as well as a medical training related to the field of practice.

PART I 3

HUMAN RESOURCES: DEVELOPING SKILLS, RESTORING PRIDE

Large organizations that have been successful have one trademark in common: they recognize the importance of the people working for them. No enterprise can achieve success merely by means of its capital or its technology. There are always people involved, those who develop projects in keeping with the company's vision, and those whose contribution is essential in carrying them out.

The greatest asset of our health system – a large service-based organization aimed at prevention, healing and administering care – is the people who work for it. It is these people who give shape to the health system's underlying values of solidarity and equity every day, and who express these values in a very real way through the service, support and compassion they extend. Our health system depends on their competence, intelligence, motivation and generosity.

Every participant in the health network, regardless of the role he plays, must be allowed to contribute to its mission, secure in the knowledge that his work is important and essential. To this end, institutions must become stimulating environments, fostering the full personal and professional development of everyone.

3.1 FINDINGS

Recent years have been difficult for the people who work in the health and social services network. To this day, overwork, the instability of work teams and shortages in some professional categories, in particular nurses, along with all sorts of inflexibilities, continue to create the general feeling of dissatisfaction, exhaustion and gloominess that too often prevail in the network's institutions.

A Serious Diagnosis

An analysis of absenteeism can be highly revealing about the state of health within an organization. According to the latest available statistics, psychological stress actually became the leading cause of absenteeism among staff between 1993 and 1999,[27] while the costs of salary insurance increased by 25%, mainly due to an increase in mental health problems related to burnout and depression. Not only is this situation causing suffering to the people concerned and their families, but it is also having an effect on the whole network, intensifying labour shortages in certain disciplines and creating enormous costs, evaluated at $350 million in salary insurance and CSST (Occupational Health and Safety Commission) expenses for the year 1999-2000 alone.[28]

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[27] MSSS, Analyse des rapports annuels des établissements (Annex AS-471).

The morale of staff appears to be no better off than its health. A recent survey revealed that 40% of those polled feel that the atmosphere at work is continuing to deteriorate, while 45% feel that employees of the network do not have a positive image of their work.[29]

Physicians appear to be equally unhappy. They complain of red tape and deplore the general conditions in which they have to practise: inadequate or insufficient facilities and equipment, lack of administrative and clinical support and inflexibility in terms of the way work is organized. Like the staff, physicians deplore the lack of control they have over their work.

These difficulties are compounded by the still very real impact of the departure of the many employees who opted for retirement packages in recent years. The general opinion is that these mass departures dramatically weakened the network's expertise and the strength of its work teams, often in sectors where it can take several years to build up collective skills. Furthermore, they have added to recruitment and labour shortage problems, which are becoming more and more acute.

These shortages are affecting nurses as well as radiation oncologists and biomedical engineering staff. If the trend continues, shortages will only get worse and begin affecting other categories of staff, most notably those working in rehabilitation and in some high-tech areas, all at a time when workload is already becoming a primary cause of psychological stress.

The network's poor record in attracting new employees is also affecting managerial staff. The issue becomes even more pressing in view of the fact that 50% of senior managers will be reaching retirement age within 5 years, while the number of first-level managers, according to many sources, is already often below the threshold number required to ensure motivating management. The lack of room to manoeuvre, combined with pay scales which are becoming less and less competitive, may well explain the difficulty the system is experiencing recruiting and retaining well-trained managers as well as keeping up the motivation of those who have been in its service for many years. To be sure, the health and social services sector must now vie with other, more competitive sectors when it comes to recruiting and retaining both management and professional staff.

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[28] Idem.

[29] MSSS, *Étude sur la fierté des employés d'appartenir au réseau de la santé et des services sociaux*, July 2000.

In fact, it is striking to note that our health system, the strength of which essentially hinges on the skill and dedication of the people who work in it, has never really recognized the strategic importance of its human resources. In most other human services sectors, this has long been recognized. Knowledge-based enterprises and firms where quality client-relations are considered to be vital find every imaginable way to outdo each other in attracting the best candidates and in providing them with a stimulating work environment, on both a professional and personal level.

The present state of affairs in the health network is hardly surprising when one looks at the extent to which the heads of its institutions find themselves practically divested of the executive powers which are considered indispensable in large service-oriented organizations. In almost all strategic areas of management, standards and directives dictate what can be done and how to do it. Collective agreements, which have been negotiated at the national level, set out guidelines for action down to the finest detail. Can an executive director be expected to have the ambition to reduce the deficit of his institution when the staff, physicians and even his own board of directors will only reproach him for it? Particularly when a neighbouring institution, which, by all accounts, has made no serious effort at getting its finances in order, will have its deficit absorbed without any penalty. Can there be any surprise at the lack of initiative and at the tendency to innovate "under the table"? Is it any surprise that many executive directors are counting the years, indeed the months left before they can retire? In the Commission's view, the difficulty that exists in filling managerial positions in the network's strategic institutions bears eloquent witness to the gravity of the problem of securing candidates for the future.

This disturbing situation can be explained in large part by the culture of confrontation and centralization that has characterized management as well as union-management relations in the public sector since the 1970s. Indeed, a great many institutions had, until then, been charitable institutions immersed in the paternalistic style of management that was commonplace at the time, and jumped straight to a centralized system of negotiation without the opportunity for a real culture of local negotiation to develop. From the beginning, the model adopted by the parties involved was patterned after industrial work relations, which were based on power relationships. The notion of the public interest or focus on the client, while essential in this field, have always been difficult to implant.

The Taylorist approach to management, as applied to the health and social services sector, has led to a task-based organization of work as opposed to one that is based on responsibility. As a consequence, the work of both support staff and professionals has become so highly compartmentalized that human resource management can now too often be summed up as the strict application of collective agreements under the equally strict supervision of unions.

This has led to a situation wherein all participants have become prisoners of the "system" they helped create. Managers, who are squeezed by all sorts of requirements, find themselves without any room to manoeuvre in a field where the utmost flexibility would be in order. Workers, on the other hand, stripped of all responsibility when it comes to organizing work at the local level, have begun to lose sight of the value of their contribution, the meaning of their work.

Here again, it is striking to note how little the health system takes into account the foremost principles of management. Indeed, it has long been understood that the job of professionals responsible for intervening in complex situations cannot be defined and described down to the last detail. The diversity and the complexity of situations they face every day require that they be allowed a great deal of autonomy if they are to apply the concepts of interdisciplinarity and continuity of service. Effective coordination of interventions requires directing action at priorities and essentially consists in facilitating work in such a way that desired results can be achieved. Clearly, this is not the case in our health system.

The seriousness of this diagnosis brings into question the culture and dynamic of the health and social services system. It sends out an urgent call to those in a position to act on this dynamic, inviting them to recognize the urgency of re-evaluating both the way human resource management is seen and how it is carried out.

Modernization of the public sector has led to the need to adopt a new management philosophy in several industrialized countries, based on engaging the responsibility and commitment of all players by involving them in a motivating project. It is the opinion of the Commission that Québec must also go this route, working to create a new management culture and organizational models that would foster motivation and satisfaction for all players, particularly the users of the services themselves. To this end, there is a pressing need to begin a profound revision of the way work is organized, giving more flexibility to institutions and health workers alike.

A VISION: COMPETENT, MOTIVATED AND STIMULATED PROFESSIONALS AND EMPLOYEES

In the vision we are proposing for the organization of services, teams of professionals will be responsible for a sector of the population. These teams, composed of professionals from many disciplines, will work together with the support of competent staff to find solutions at their level that are well-adapted to the specific needs of the people they serve. They will have the power and autonomy necessary to implement the solutions they choose. They will be responsible for offering the best possible service and for coordinating their efforts with those of other teams and players in order to ensure continuity of service. They will set clear objectives, formulated in terms of the results to be achieved. They will evaluate the impact of their interventions in light of these objectives, working to improve their performance.

Both professionals and employees will come to the health system with the basic training needed to prepare them for the demands of interdisciplinary teamwork and to enable them to intervene more effectively in cases where clients are dealing with complex problems. They will be better-equipped to respond to the demands of people who wish to be informed and to participate in the decisions and interventions concerning them. They will be well-prepared to face change and to adjust their practices so as to integrate advances in knowledge and technology. They will work constantly to improve their practices, supported by continuing education programs designed according to their needs and to the expectations of their managers.

Throughout their careers in the network, the members of these teams will be given many opportunities to upgrade their skills and take on new responsibilities, either within the institutions they work for or within their communities. Many of these players will participate in training the increasing numbers of young people choosing a career in the various health and social services disciplines.

First-level managers will act as facilitators for interdisciplinary teams. They will encourage initiatives and foster the emergence of projects aimed at improving practices, based on client needs. Professionals and managers will openly discuss desired results and the expected contribution of all participants. They will work together in a climate of cooperation, evaluating the results of interventions and needs for improvement.

For their part, heads of institutions will be increasingly called upon to meet real managerial challenges: defining an inspiring vision and communicating this to all members of the organization, offering motivating leadership, placing value on the contribution of each player, and ensuring that the organization contributes fully to the achievement of regional and national objectives. The great strength of management teams will be expressed, above all, through their capacity to create a climate of confidence and to instill in others the desire to succeed. Their main objectives will be to anticipate change, offer direction and mobilize the energy of all players around stimulating projects which are beneficial to the population, as well as to internal partners and to the whole of the health and social services system.

Our network will thus be recognized as a responsible employer, one which encourages innovation, participation and the continual development of the potential of those who work within it. Well-trained and enthusiastic young people will be ready to take over, sure to find in the network a stimulating environment that offers challenges equal to their ambitions. Ours will be among the best performing health systems because it will recognize that its adaptability and its future depend on its human resources.

3.2 GUIDING PRINCIPLES

The Commission has laid out the following five underlying principles as a guide to human resource management within the network's institutions.

1) **A stimulating work environment** offering sources of motivation and satisfaction to each worker every day.
2) **Results-based management** which allows every manager appropriate latitude in organizing work with his teams in accordance with desired results.
3) **A modern, flexible and well-adapted organization of work** in which each member of the organization feels he has some control over his work and where the responsibilities correspond to appropriate levels, following the principle of subsidiarity.
4) **Competence is highly valued** such that every worker can be confident that his efforts at professional development and at keeping up to date with advances in knowledge will be recognized and encouraged.
5) **Continual attention given to the education and training of future workers** with each organization carrying out strategic planning of future labour needs and carefully preparing those who will take over.

3.3 RECOMMENDATIONS

3.3.1 TAKING ACTION TO COUNTER THE GLOOMY OUTLOOK OF WORKERS

R-11 We recommend that

> **The main players in the health and social services sector, in particular the Conseil du Trésor (Treasury Board), the MSSS, the unions, professional associations and corporations as well as institutions and the health-care facilities under their authority, recognize the urgent need to counteract the low morale and lack of motivation prevalent among staff in the health sector.**

The Commission is not the first to sound the alert about the human resource situation. It is high time an urgent call be sent out to those in a position to act and to join their actions on this issue. All players must recognize that strategies aimed at protecting special interests lead to deadlock and hurt the organizational well-being of the whole network.

The future of the health and social services system calls for the emergence of a new dynamic. Players at the highest levels must concert their efforts to create the impetus necessary to allow doctors, nurses and other members of staff, both individually and collectively, to regain a sense of satisfaction at work as well as the capacity to adapt and better respond to the needs of the population.

3.3.2 IDENTIFYING A PROJECT FOR EVERY INSTITUTION

This recommendation is supported by 1 proposal:

P-33 We propose that

Each institution within the health system plan a business plan type of organizational project in which managerial staff, professionals and other employees join together to improve client services.

Working within the network means first and foremost working for the well-being of people. There are few enterprises that can boast such a noble and essential mission. However, over the course of time and after major upheaval, our system has lost sight of this inspiring mission.

It is the Commission's opinion that the health system's foremost mission must be given the priority it deserves: it alone is capable of inspiring workers who have lost their motivation and developed a negative image of their jobs, re-igniting their desire to work hard and stretch their limits. The projects we are proposing are aimed at refocusing efforts on the real needs, that is to say, on the needs of the population, and at raising the level of satisfaction of the people at the heart of the system's mission.

Several institutions and their teams are already interested in a client-based approach. However, few have succeeded in overcoming systemic resistances and in making this the basis for organizing services. Often the elements that are essential to the success of this approach – open management, continuing education, real decentralization in decision-making and respect for the people involved – are only given lip service.

The Commission calls on local teams to take over control of the organization of work, ensuring that things run smoothly. It is at the institutional level that decisions and actions must be taken in this regard in order that every worker can offer the best possible service and gain the greatest satisfaction from his work.

These projects would allow each player to contribute to the improvement of services and to take initiative in his work. Within the proposed framework, work teams would be able to do something about how they function. Each participant would be aware of what contribution was expected from him, and would have the means at his disposal to develop his potential and improve the quality of his contribution.

Before engaging in this path, work teams will need assurance that their managers will listen to them when they ask for or suggest ways to make their work easier or more enriching and to bring their knowledge up to date. They will need the material and moral support of superiors who believe in this process and who have the knowledge and the resources necessary to assist them in it.

Organizational well-being demands that work teams be given more confidence, recognizing that these teams are in the best position to specify how work should be organized and what means are most likely to be successful in improving the quality of services delivered to the population. It is the Commission's opinion that players on all levels must focus their efforts on creating the kind of environment that will allow these teams to achieve their full potential.

3.3.3 RECOGNIZING AND REINFORCING THE ROLE OF EXECUTIVE DIRECTORS

R-12 We recommend that

The Conseil du trésor, the MSSS and the regional boards fully recognize the strategic role of executive directors in the management of their institutions as well as in achieving national and regional objectives concerning service organization, the motivation of staff and financial performance.

This recommendation is supported by 2 proposals:

P-34 We propose that

Executive directors be given more room to manoeuvre and be held more accountable;

P-35 We propose that

- **Their compensation be revised according to a comparative market analysis;**
- **A significant portion of their remuneration be tied to the results achieved by their organization.**

The executive director is key to the successful operation of an institution and must be recognized as such at all levels within the network. Each executive director must actively participate in determining which results should be expected from his organization and be held accountable for these results. It is his role, in collaboration with his management team and internal partners, to establish the most appropriate ways to achieve these goals. The executive director must therefore rapidly be given the means with which to organize services and set up a system of accountability based on results rather than on the means used to accomplish them.

It is the Commission's opinion that our network must revise its notions of management and leadership. In our view, the head of an organization is responsible for upholding its mission and ensuring that this mission gets carried out. No matter what the circumstance, he makes sure that the institution stays on track towards a specific destination, known to every member of the organization. It is he who mobilizes the efforts of every member towards achieving this goal. Recognizing that a concerted effort is essential, he listens and is sensitive to the needs of staff and of his partners. He has confidence in and counts on the competence of the members of his team. He is able to recognize talent and encourage initiative. He appreciates his colleagues and takes every opportunity to show them his appreciation and to support them in their development. He maintains clear communication with those he works with, thus enabling them to make adjustments where applicable. He is recognized for his sense of equity and for his integrity, and is appreciated both as a person and as a leader.

We believe that many executive directors within the network aspire to this model and are willing to invest the time and effort needed to conform to it. It is our view that, as much for them as for those who will succeed them, the MSSS must redefine the career profile of executive directors, supporting the development of those who are already in the position, and preparing future executive directors in such a way as to enable them to instill vision, communicate and direct action towards better responding to the needs and expectations of the population.

It is our opinion that, in order to strengthen the role of the executive director, there needs to be tangible recognition of his need for greater scope for action when it comes to service organization and human resource management. Executive directors would like to be assured the confidence and support of their superiors. In return, they will have to orient their actions towards achieving specific objectives as well as become accountable for the results obtained by their organizations.

3.3.4 PREPARING FUTURE EXECUTIVE DIRECTORS

R-13 We recommend that

The MSSS develop and implement a national program aimed at preparing future executive directors.

The vast majority of today's executive directors will be leaving within 10 years. Therefore, it is time to identify the people who will be able to take over from them, put appropriate training programs in place and offer proper support to the people who have been identified.

The Commission is of the opinion that, in order to prepare for the filling of future executive director positions, the MSSS must put into place a national program featuring the following characteristics:

- It counts on the collaboration of all the executive directors of institutions and regional boards to identify potential candidates, based on a clear set of criteria;
- It includes a rigorous process for evaluating potential;
- It provides for individualized developmental programs.

In addition to this program, the working conditions of managerial staff must be modified so as to offer learning opportunities such as continuing education programs, access to assistant director positions, interim positions or practical training periods. In the same vein, members of work teams and professionals need to be supported financially so as to foster the acquisition of new skills and experience.

3.3.5 WORKFORCE PLANNING

According to several experts that we consulted, workforce planning will constitute the single most important activity of the coming years. On top of present staff shortages will be added the challenge of encouraging young people to pursue careers in the health and social services sector and of creating attractive work environments for them.

Strategies aimed at recruiting and retaining staff can therefore no longer be limited, as is too often the case, to finding selective solutions to shortage problems, or, even worse, to resorting to the types of incentives which have the effect of "robbing Peter to pay Paul." In our opinion, efforts to recruit and retain staff must not only aim to turn around these shortage problems, but also to provide for a qualified, competent workforce which is capable of adapting to evolving client needs and technological developments.

This preoccupation with workforce planning must be present and intense at all levels of management. The health system must stop reacting. It must provide itself with the means necessary to anticipate change and prepare for it accordingly.

Within the institutions themselves, workforce planning should become an integral part of every strategic planning step taken. The regional boards should support the institutions in this process and ensure that regional plans for service organization are in line with workforce needs. The boards will thus be better equipped to support local development and recruitment strategies. Teaching institutions could be made partners in these strategies and adapt training programs to local and regional needs.

For its part, the MSSS must ensure that these efforts are well coordinated and develop a global strategy aimed at meeting workforce needs for all categories of staff throughout Québec. It is the responsibility of the MSSS to make these needs known to teaching institutions, in particular the universities, so as to guarantee that a sufficient number of professionals, trained for the realities of the health network, will be entering the labour market.

Furthermore, there needs to be some provision made for the anticipated turn-over in staff over the next few years, as experienced professionals begin to retire and large numbers of young professionals arrive to replace them. On the one hand, these departures must not be allowed to bring about an overly substantial and sudden loss of expertise, which would have repercussions on the quality of care and service. On the other hand, new staff must not arrive at a workplace which is devoid of experienced staff and which does not offer them sufficient supervision and support. Such a loss of expertise is undesirable both for the quality of service and for the young professionals themselves.

A true culture of renewal, in which the transfer of expertise is recognized as central, needs to be integrated into the running and organization of services. This culture needs to permeate the process of workforce planning, without creating extra work for those who embrace it. Mentoring arrangements offer many advantages in this respect, facilitating the integration of young members of staff while making the mentors feel valued. As the latter are usually professionals at the end of their careers, this system allows for the transfer of knowledge which has been acquired over many years of experience.

R-14 We recommend that

- **The MSSS, the regional boards and the institutions establish a permanent workforce planning process;**
- **They also set up a monitoring system, which would enable them to ensure the availability of a workforce that is sufficiently large and qualified to meet the needs of service organization.**

This recommendation is supported by 5 proposals:

P-36 We propose that

The MSSS, together with the MEQ, the universities and the regional boards, work to develop a permanent process for keeping track of needs in order to better anticipate the qualifications and staff numbers required to maintain the provision of services throughout Québec;

P-37 We propose that

The MSSS, the regional boards and the institutions develop mechanisms, such as orientation, continuing education, professional development, career-path assistance and retirement planning programs in order to respond appropriately to the evolving needs of the various groups of graduates that arrive;

P-38 We propose that

The regional boards actively support the steps taken by the institutions by providing coordination of local programs and by implementing regional strategies aimed at recruiting and retaining staff, in accordance with service organization plans;

P-39 We propose that

Workforce planning become an integral part of strategic planning within each institution;

P-40 We propose that

Mentoring systems be put into place in the institutions to provide for the transfer of expertise.

3.3.6 MAKING SKILLS A PRIORITY

R-15 We recommend that

Staffing procedures be modified so as to make skills a top-priority selection criterion.

There is no doubt that the model proposed by the Commission recognizes the paramount importance of skills. It is our opinion that executive directors, as well as managerial staff, professionals, technicians and all other members of the organization, must invest in upgrading their skills if they wish to be in a position to face the challenges of the future.

Is it possible, in this context, for the preponderance of competence to co-exist with the system of seniority which is fundamental to the sector's collective agreements? In the Commission's view, these two notions do not necessarily conflict with one another; neither can one replace the other. Experience that has been acquired over many years is invaluable. However, skills acquired through formal training and continuing education are equally valuable. The current predominance of seniority is not highly compatible with continuing education programs, and is no longer well-adapted to the contemporary context.

Rules based on seniority were negotiated at a time when the demands of technology were not as extensive as they are today, and when it was possible to substitute one person for another fairly easily. In the Commission's opinion, this concept of work is no longer appropriate in today's context where the strength of work teams hinges on individual and collective competence and experience. It is our understanding also that work should be an important source of personal growth and satisfaction. Needs have changed and work must now offer the possibility of personal development and fulfillment, particularly in sectors where innovation is possible. The institutions in the network offer just such a potential and this potential will surely grow stronger in the service organization model that we are proposing. It is our conviction that competence and skill make a world of difference in the health and social services sector for workers, for the organizations involved and for the population at large.

The object of this approach is not to judge anyone or to introduce arbitrary measures into staffing procedures. Its aim, rather, is to ensure a closer match between skills which are available and those which are in demand. It must go hand-in-hand with continuing education programs which allow each employee to develop skills that correspond to the needs at hand, the tasks to be performed and the responsibilities to be taken on. Its objective is to offer all players opportunities for development and increased satisfaction from work.

This recommendation is supported by 1 proposal:

P-41 We propose that

Continuing education and professional development programs be set up in every institution.

3.3.7 FOSTERING INTERDISCIPLINARITY

R-16 We recommend that

The framework within which health professionals practise be revised to create the conditions necessary for interdisciplinary work.

This recommendation is supported by 3 proposals:

P-42 We propose that

Teaching institutions adapt training programs designed for future professionals in the health and social services sector to fit with the new realities of the health system and with the demands of interdisciplinary work;

P-43 We propose that

The Groupe de travail ministériel sur les professions de la santé et les relations humaines (Ministerial task force on health professionals and human relations) attach the utmost importance to breaking down barriers between the professions and to developing interdisciplinarity while ensuring the protection of activities that require a unique and complex level of competence;

P-44 We propose that

The Groupe de travail multipartite sur l'allègement de la réglementation (multi-party task force[30] on regulatory relief) foster simplification of the procedures governing professional corporations.

The Commission urges all professionals to adopt a contemporary practice, one which corresponds to the needs of the population and meets the highest standards of quality. The individuals and groups who addressed the Commission are calling for services that are accessible, integrated, personalized, continuous and high-quality services. Where sickness or psychosocial problems exist, people would like to have access to competent professionals who are sensitive to their situation and who have at their disposal the necessary means to intervene effectively and quickly. They have great sympathy for health professionals, but are no longer willing to compensate for the lack of coordination between the institutions and the professionals responsible for procuring the care and service they need. In other words, interdisciplinary work teams are no longer a choice. They have become a necessity.

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[30] Idem.

During national Commission hearings, professional groups acknowledged the urgent need for this change in direction and offered their cooperation. Each group called for its own sphere of practice to be broadened, although not necessarily shared. It is well known, however, that current professional practices work against the integration of services, fostering instead a system of separate "silos" of professional practice and imposing major constraints on the development of interdisciplinary work.

It is generally agreed that there needs to be action on several fronts to turn this situation around. Hence, it is our belief that all possible steps must be taken, in particular at the legislative level, to facilitate the efforts of professional corporations that embark upon the path of openness and innovation. At the same time, innovative practices which have sprung up on the ground to deal with the demands of service should be looked at more closely. Most often, these new practices sit on the periphery of official rules, in grey zones on which it could well be to our benefit to shed some light. The experience of societies which are comparable to ours should also guide our reflection and our choices concerning the possibility of extending certain fields of practice. Such reflection is particularly imperative in the case of nurses, who are called upon to play a front-line role in the service organization proposed by the Commission.

Developing interdisciplinary teamwork will also require that the curricula of professional training programs be revised. It is our observation that health professionals are in fact little or even ill prepared for interdisciplinary work by present basic training courses. It is our opinion that professional training programs in health and social services must develop closer ties to the workplace in order to take into account the realities of interdisciplinary teamwork.

The proposed changes in service organization correspond to a contemporary vision of professional practices. They imply legal recognition of new roles for nurses, among others, a new division of responsibilities among professionals and the loosening of regulations governing the professions.

According to the information at our disposal, the Groupe de travail ministériel sur les professions de la santé et les relations humaines set up by the Minister of Justice in February 2000, should aim for solutions which foster legal recognition of practices, as well as cooperation and sharing of responsibilities among professionals, while safeguarding each profession's particular skills. In order to facilitate the sharing of responsibilities, which is a delicate issue, we believe that it would be pertinent to study the possibility of integrating professionals working in the same sphere of activity into a single professional corporation, and to examine all other means of facilitating cooperation between different professional groups.

Moreover, the general opinion is that legislation governing the professions must also be loosened as soon as possible to facilitate adaptation to new trends and to developments in technology. Considering the responsibilities entrusted to professional corporations where public protection is concerned, it is our belief that regulations must also be adapted to give these corporations more latitude in implementing changes along these lines.

3.3.8 REINFORCING THE POWER OF LOCAL PLAYERS

R-17 We recommend that

The players concerned commit themselves to determining ways, at the local level, to take over matters related to the organization of work.

This recommendation is supported by 1 proposal:

P-45 We propose that

Players at the national level acknowledge that questions pertaining to work schedules, temporary replacement, attendance at work and position management should be negotiated and ratified at the local level before the beginning of the next round of national negotiations.

All of the Commission's recommendations are directed along the lines of open, transparent and responsible management, and are aimed at improving the quality of service delivered to the population as well as at contributing to the satisfaction of staff. In accordance with our vision of management, those who are being asked to achieve results regarding services should have the necessary means at their disposal to determine how to adapt the organization of work to fit their own situation as well as that of their clientele.

It is the Commission's opinion that players at the local level must gradually take control of negotiations pertaining to the organization of work, with priority given to those regarding work schedules, temporary replacement, attendance and position management. This must be accomplished in a "tension-free" context and must take into account the fact that there is no real negotiating tradition at the local level. Thus, players at the national level would be well-advised to begin now, taking advantage of the calm between negotiations to initiate discussions on the best way to negotiate local agreements at each institution on these 4 questions.

3.3.9 REDEFINING MOBILITY

R-18 We recommend that

The parties concerned come to agreement on a new definition of the notion of mobility, one which is better adapted to the recommended service organization.

This recommendation is supported by 1 proposal:

P-46 We propose that

Union organizations undertake, locally, to agree on a set of rules which would allow for the mobility of staff between affiliated bargaining units and, when applicable, between institutions serving a given population.

The Commission has not called into question job security in the health and social services sector. It is our view, however, that the low mobility of staff, attributable mainly to the high number of bargaining units, unduly hinders the manoeuvring room of institutions and the normal career path of employees within a given service organization. We understand that this situation has its roots in the very history of our health network and that it is closely linked to the development of the professions and the specialization of tasks which have led to the original units being broken up.

However, while the health system has managed to accommodate this situation for a long time, it must be acknowledged that this is no longer the case. Following the mergers that have taken place in recent years, some institutions are actually finding themselves in the intolerable situation where a single job category is sometimes represented by several unions. This goes against the basic rules and the clear intention of the Labour Code, which stipulates one unit of negotiation for all employees in a single job category, and it also goes against all common sense.

The integration of services, which is so important for the future of our health system, is also being hampered by some of the current rules, in particular the rule which makes provision for the acquiring of seniority "in silos", or, in other words, by bargaining unit and by institution. Here again, current rules restrict the mobility of staff, opportunities for professional advancement and, by this very fact, the ability of each institution and of the whole network to achieve its objectives.

It is the Commission's view that mobility must stop being perceived as a threat to job security or to the quality of life of employees and that the notion of mobility needs to be redefined in accordance with contemporary realities. In the service organization that we are proposing, based on a population or territorial approach, mobility should be seen as a tool to be used to the benefit of individuals and organizations. It would allow individual workers, particularly younger ones, to gain experience and develop skills which could in turn lead to the possibility of moving on to new responsibilities. Hence, these employees could enjoy a stimulating career in the health network, with easy access to positions in its various institutions. In this way, mobility would become a factor of stability and a source of recognition rather than just a bureaucratic rule. We are conscious that this presents a completely different perspective on the matter than the one that is currently in place in our network. However, we are truly convinced of the validity of this approach and we strongly urge the parties concerned to engage in discussions on the question of mobility.

It is the hope of the Commission that central union organizations will intervene to support the merger of affiliated unions that represent the same job category for the same employer. In the Commission's view, however, the mobility of employees within a single institution and between various institutions must still be the final objective, irrespective of the number of bargaining units.

In a network of services where the ties between institutions should be strengthened to ensure a better integration of services, it is the Commission's belief that the parties concerned must facilitate mobility between institutions, agreeing to accept either the transferability of seniority from one institution to another, as is the case for job security measures, or the adoption of network-wide seniority.

The Commission therefore urges all parties to determine a set of rules which would allow for mobility between bargaining units. The recent experience of the Centre de réadaptation en déficience intellectuelle Gabrielle-Major (Gabrielle-Major Centre for Rehabilitation in Intellectual Deficiency) is an example that such agreements are both possible and desirable.

PART I 4

PUBLIC FUNDING:

STRENGTHENING SOLIDARITY THROUGH PERFORMANCE

4.1 FINDINGS

4.1.1 FROM INSURANCE TO A RIGHT

The notion underlying our health and social services system is that there should be public insurance to protect against the serious risks related to illness, that is, mainly "curing" and "caring." When the system was first established, the aim was to provide every person with access to hospital services, and later to medical services, regardless of ability to pay. This is why the two primary pillars of the current system were called "hospital insurance" and "health insurance."

In Québec as elsewhere, needs have gradually evolved and a wide range of other health and social services are now paid for by the state. Some are governed by specific laws, for example the services provided for under the *Youth Protection Act*, and others are complementary programs administered by the RAMQ. Still others are covered, in principle, by the general budgets of institutions pursuant to the *Act respecting health services and social services*, but they are not precisely defined.

Over the years, the concept of "public insurance" has gradually been supplanted by the idea of "individual right to service," and with it the idea of a well-defined basket of "insured" services has also disappeared. It is not surprising that in Québec, as elsewhere in Canada, there is no longer anyone who can say for sure, without consulting a lawyer, exactly what services are really insured, within what time period, by whom and in what circumstances they must be produced. Nor can anyone say, without consulting an accountant, how much the various categories or units of services cost or what criteria are used to decide which services are insured and which are not, let alone where the money comes from and where it goes.

The *Canada Health Act*, which was passed in 1984, enshrined the five principles of universality, accessibility, comprehensiveness, portability and public administration, principles that no one seriously challenges.

These principles are still socially legitimate, though they now need to be modernized. Interpreting these principles according to the prevailing reality of yesteryear only creates inconsistencies, making it difficult to see the logic of the system.

4.1.2 MAKING CHOICES AND PERFORMING

In its report of June 2000, the World Health Organisation (WHO) emphasized two fundamental ideas that are sometimes forgotten in the health and social services field.

The first is the obligation to make choices, to define priorities in order to determine the content of the envelope of benefits or basket of services to be provided to everyone. WHO points out that no system in the world, no matter how generous, can offer every possible service to everyone free of charge. All systems "ration." This is an essential function of national governance: *"All countries need explicit policies to ration interventions and to ensure that limited resources are spent in high priority areas."*[31] Private funding systems rely on market mechanisms to do the rationing whereas public systems define a range of services to be covered and establish the public budgets to be allocated to them.

The second notion, performance, which is both the principal theme and the raison d'être of the WHO report, refers more particularly to the improvement of the performance of health systems. The term performance is used here in its most noble sense, that is, the achievement of the best results possible given available resources.

The notion of performance raises a number of universal questions. Are the right services being insured? Are we getting the most for our money? Is our system economical, effective and efficient?

The Commission became convinced, during its meetings with some thirty international experts, that no developed country with a publicly funded health system can avoid the two following obligations: to make choices and to perform well. In the opinion of many people, these two obligations are the prerequisites for maintaining the solidarity and equity upon which public systems are based. In fact, the absence of clear choices and satisfactory performance threatens the values of solidarity and equity which underpin public systems. In the health sector, the major choices are clearly a political responsibility. Failing this, budgets or, ultimately, the courts will dictate these choices. Performance therefore results from the concerted action of governance, management and professionals.

Fundamentally, there is an obvious need to return to the original concept of a "collective insurance system" administered by the state and funded through taxes. A review is necessary in order to determine which services should be insured, which services should be provided, within what reasonable time period, for whom, by whom and where. We must define the most appropriate organization of services and decide how to manage this organization effectively.

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[31] World Health Organisation, *The World Health Report 2000 — Health Systems: Improving Performance*, Geneva, 2000.

It must also be determined, in a transparent way, what financial resources are available, where the money comes from and where it goes. Which budgets are devoted to which services and why? What are the total costs and unit costs of each program? How do these costs in Québec, Canada and other countries compare with each other?

It is absolutely essential that we answer these basic questions about insured services, the amounts of premiums, the costs of services and the performance of service providers. Any insurance company that could not answer these questions would be unable to manage and would soon be bankrupt. Unfortunately, today we are unable to answer most of these questions for the majority of our service programs.

Answering these questions will require determination and clear-headedness, courage and rigour. It will require us to make choices in defining insured services, to indicate the limit of the state's financial contribution, to measure both the clinical and financial performance of providers, to deal with all the issues in a transparent way and to agree to invest the time and energy needed to accomplish this task.

A VISION: RENEWING ORGANIZATIONAL CULTURE AND MANAGEMENT

To change our system successfully, the culture of the network and of its management must also be changed.

Québeckers would not be satisfied with mediocre, poorly organized and costly health services that are not centred on the client at a time when all other sectors are modernizing, adapting themselves and improving their performance. It is absolutely necessary to adopt a culture of excellence, based on performance measurement. All countries that have publicly funded systems, in Europe and elsewhere, are moving resolutely towards new strategies designed to provide the incentive to improve performance and to measure results. We must do the same.

The culture of our network is based on a hierarchical, bureaucratic and compartmentalized approach whereby each new client represents a new problem. A culture of excellence needs to be developed, one that is based on results and in which objectives and the means to attain them are established through governance.

National-level governance must be more strategic and provide a leadership reinforced by a capacity to predict, make major choices, establish objectives, and measure results. Regional-level governance will be accountable for putting the operational objectives into action within the framework of performance contracts that are negotiated every year under a three-year plan. Institutions will have a population-based and territorial responsibility. They will negotiate performance contracts with the boards and will thus have the flexibility needed to be truly accountable.

Instead of excluding the private sector, partnerships will be established where they can make the system more economical, efficient and effective, thus contributing to its sustainability. Partnership will also be the basis of the network's relationship with the third sector. Relations between the various components of the system will evolve towards contractual relations, thus putting into action the concept that "the money follows the patient" and introducing the measurement of the results expected by the purchaser. The entrepreneurial spirit will replace strict following of orders, that is, the sense of innovation will replace the sense of obedience.

Competition, based on the ability to provide quality services, will replace lobbying and pressures from the producers of services, whether institutional or professional. Budgeting and mechanisms for paying all the players will be based on performance rather than on history or status. Primary care clinical teams will increasingly control the purchase of the best services at the best price for their clients. Finally, the regions will negotiate, with specialized institutions in the major centres, the purchase of services and the establishment of corridors, or fast lanes, for their clients.

To sum up, a new paradigm based on the culture of excellence – i.e., the ability to innovate, to take action and to measure the results obtained – will replace the old paradigm based on protecting one's turf, organizational conformism and the use of deficits to press for additional funds. The emergence of this new paradigm will protect against a multi-tiered system being created.

In the Commission's opinion, this is not only a vision of what is desirable but of what is absolutely essential if we want, collectively, to both maintain the foundations of our system and continue to adapt it to today's new needs.

4.2 GUIDING PRINCIPLES

The Commission's analysis and recommendations in the area of financing of services are based on the following principles:

1) Insured services meet the population's priority needs;

2) The basket of insured services is clearly defined, provides timely access to services, and receives adequate funding to do so;

3) The basket of services defined by public authorities remains, for the most part, publicly funded;

4) Public funding goes hand-in-hand with a high level of transparency in terms of both the level and sources of funding and the methods of allocation, payment and cost of services rendered;

5) Funding – its level, sources, methods of allocation and payment – reflects our society's major choices and values as regards health and social services;

6) Public funding of services requires permanent, transparent monitoring of the growth in expenditures in relation to the state of public finances and collective wealth;

7) The financing of the entire network provides the incentive to institutions and professionals to improve both clinical and financial performance.

4.3 RECOMMENDATIONS

4.3.1 FINANCING: DEFINITIONS

From the outset of its deliberations, the Commission indicated that it would address several aspects of the topic of health and social services financing: the level of funding, the sources and distribution of money through resource allocation and the mechanisms for paying the players. Many groups, individuals and experts have expressed opinions on this subject.

During our consultations, it was noted that there was great confusion over the notions of public versus private funding, insured versus uninsured services and public versus private production of services, as well as public versus private management. In order to shed some light on these concepts, the Commission has set out a number of definitions (see Annex 2).

We also realized that many organizations and citizens are quite unfamiliar with the basic facts on this subject, due no doubt to the lack of clarity in funding mechanisms for services paid by the state. They express either worries, which are often unfounded, or a reckless confidence in our collective capacity to sustain funding. Some key concepts are worth recalling for those who wish to form an opinion on these issues.

4.3.2 LEVEL OF FUNDING

Comparisons with other similar systems and countries can be made in order to determine whether we spend more or less on health services than other societies do. The two most frequently used indicators are expenditure per capita and public sector health expenditure as a percentage of GDP.

TABLE 1 Public Health Expenditure Per Capita, Québec, Canada and Major Provinces – 1990, 1995 and 1998 (In Dollars)

	1990	1995	1998
British Columbia	1,641	2,003	2,072
Canada	*1,644*	*1,805*	*1,946*
Ontario	1,685	1,819	1,919
Québec	**1,547**	**1,756**	**1,897**
Alberta	1,701	1,578	1,837
Québec-Canada Difference	**– 6.3%**	**– 2.8%**	**– 2.6%**

Note: Including direct federal government expenditures (aboriginals, armed forces, veterans) and provincial government social security funds (CSST).

Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975-2000*, Ottawa, 2000.

TABLE 2 **Public Health Expenditure as a Percentage of GDP, Québec, Canada and Major Provinces – 1980, 1990, 1994 and 1998 (In Percentages)**

	1980	1990	1994	1998
British Columbia	5.6	6.9	7.1	7.3
Québec	**6.6**	**6.9**	**7.2**	**7.2**
Canada	*5.5*	*6.8*	*6.9*	*6.5*
Ontario	4.8	6.2	6.6	5.9
Alberta	3.9	6.4	5.5	5.0
Québec-Canada Difference	**+ 1.1**	**+ 0.1**	**+0.3**	**+ 0.7**

Note: The provinces are ranked in decreasing order of 1998 values.
Sources: Ministère de la Santé et des Services sociaux (MSSS), *Le financement du système public de santé et de services sociaux au Québec*, Quebec City, June 2000; Canadian Institute for Health Information, *National Health Expenditure Trends, 1975-2000*, Ottawa, 2000.

According to the most recent data from the Canadian Institute for Health Information (CIHI), public sector health expenditure per capita in Québec is slightly lower than the Canadian average (Table 1). Nevertheless, in proportion to our GDP, it is equivalent to that of British Columbia but higher than that of Ontario, Alberta and the Canadian average (Table 2). The CIHI data on public sector health expenditure per capita, adjusted for differences in age and sex of provincial populations, indicate that Québec spends more per capita than six other provinces.

Two indicators used to compare Québec with a number of countries show that Québec is at neither extreme of the statistical distribution (Tables 3 and 4).

TABLE 3 **Total Health Expenditure Per Capita, Québec, Canada and OECD Countries, 1970, 1985 and 1997, measured by purchasing power parity ($ PPP)**

	1970	1985	1997
United Kingdom	144	669	1,391
Italy	154	830	1,613
Japan	131	820	1,760
Sweden	270	1,172	1,762
Québec	**247**	**1,153**	**2,003**
Denmark	216	1,173	2,042
France	206	1,082	2,047
Canada	*262*	*1,201*	*2,175*
Germany	224	1,242	2,364
Switzerland	252	1,250	2,611
United States	357	1,798	4,095

Note: The countries are ranked in ascending order of 1997 values.
Source: Ministère de la Santé et des Services sociaux (MSSS), *Le système québécois de santé et de services sociaux* (benchmarks), Quebec City, June 2000.

TABLE 4 **Public Health Expenditure as a Percentage of GDP, Québec and OECD Countries, 1993, 1995 and 1998 (In Percentages)**

	1993		1995		1998
United Kingdom	5.8	United Kingdom	5.8	United Kingdom	5.6
United States	6.1	United States	6.5	United States	6.1
Denmark	7.2	Canada	6.7	Canada	6.5
Canada	*7.3*	*Denmark*	*6.8*	*Denmark*	*6.8*
France	7.3	Québec	7.1	Sweden	7.0
Québec	**7.6**	**Sweden**	**7.1**	**Québec**	**7.2**
Germany	7.7	France	7.3	France	7.3
Sweden	7.7	Germany	8.2	Germany	7.9

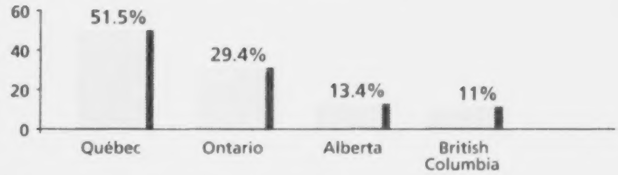
Sources: Ministère de la Santé et des Services sociaux (MSSS), *Le système québécois de santé et de services sociaux* (benchmarks), Quebec City, June 2000; Organisation for Economic Co-operation and Development, *OECD Health Data 2000: A Comparative Analysis of 29 Countries*, Paris, 2000.

Several groups used these same data to support conflicting theories. In our opinion, they simply serve as useful benchmarks. To evaluate the capacity or flexibility of a government to maintain or increase public spending, its level of overall debt per capita must first be considered because the interest payments on the debt it has accumulated over the years reduces its manoeuvring room.

Québec's public debt is in the order of 100 billion dollars. As a percentage of GDP, our indebtedness is the highest in Canada (Figure 4). Interest payments on this debt amount to more than 7 billion dollars per year, which is roughly equivalent to 20% of the income and other taxes paid to the Québec government.

FIGURE 4 Gross Debt at March 31, 1999 (As a Percentage of GDP)

Indebtedness of Québec and Major Provinces

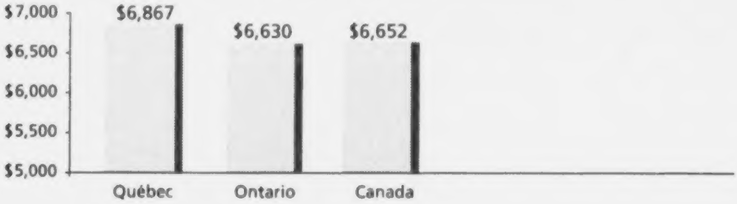


Source: Ministère des Finances, 2000

On the other hand, our per capita public spending is slightly higher than elsewhere in Canada (Figure 5), despite lower wealth per capita (Figure 6). This is due to the fact that Québec has made its own distinctive choices in the field of public services and social policies.

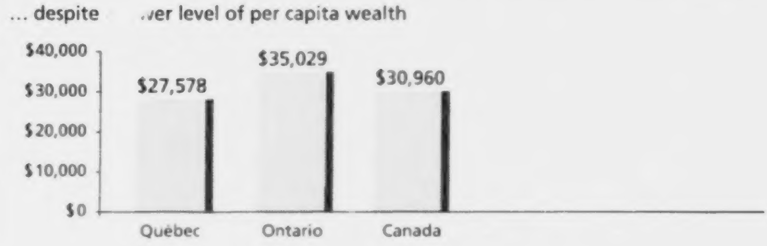
FIGURE 5 Program Spending, Provincial and Local Authorities (1998-1999) (In Dollars Per Capita)

Per capita public expenditure is higher in Québec than elsewhere...



Source: Ministère des Finances du Québec, 2000

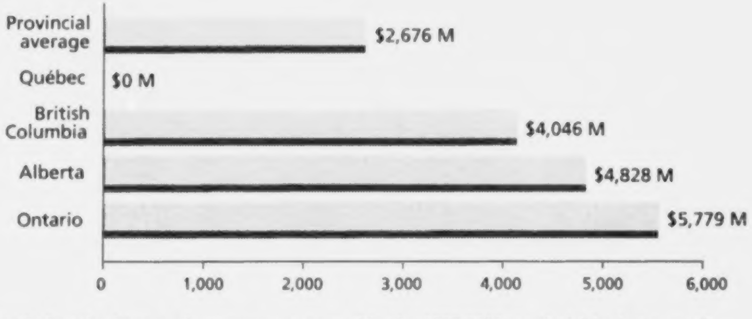
FIGURE 6 **Per Capita Gross Domestic Product, 1999 (In Dollars)**



Source: Ministère des Finances du Québec, 2000.

The inevitable result is that Québec has a very high tax burden (Figure 7). This is especially true for personal income tax: in 1999, Québeckers paid an average of 20% more than they would have if the income tax system of the other provinces had been applied to Québec.

FIGURE 7 **Personal Income Tax Difference between Québec and Other Provinces, 1999⁽¹⁾ (In Millions of Dollars)**



(1) Including the impact of measures announced in the 1999-2000 provincial budgets, as of October 1, 1999. The calculation of the tax effort of individuals in each province takes into account tax rates, surtaxes, tax credits and provincial child benefits. In Québec, payments to the health services fund and the anti-poverty fund are included in the tax effort. Lastly, the 16.5% Québec tax abatement is deducted from the difference in the tax effort.

Source: Commission parlementaire sur la réduction de l'impôt des particuliers, *Effort fiscal comparé des contribuables québécois à l'impôt des particuliers*, Quebec City, 1999.

Based on the 2000-2001 budget forecasts of the other provinces, these relative differences will not change very much before 2005.

As for corporate taxation, for a number of years the tax rates in Québec have been similar to or lower than the rates in Ontario. This competitive advantage will be difficult to maintain since Ontario has announced a significant decrease in the corporate tax burden between now and 2005. This comparison with Ontario is relevant because its economy, which is almost twice as large as ours, is our main competitor.

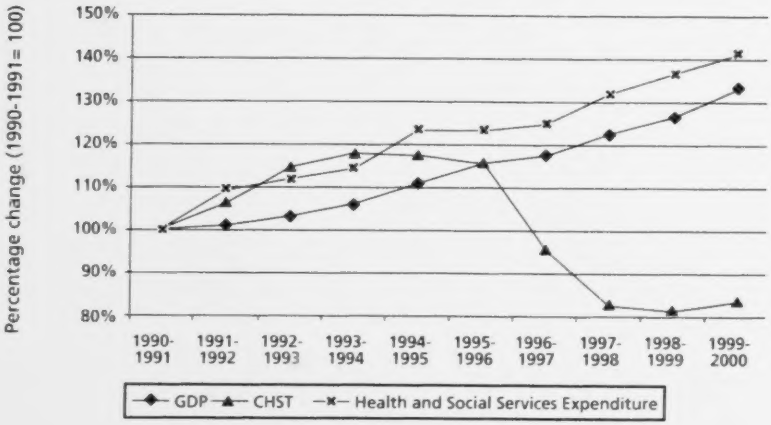
4.3.2.1 TRENDS IN THE GROWTH OF PUBLIC SPENDING ON HEALTH AND SOCIAL SERVICES

Although in 1998 Québec was in a comfortable position, statistically, in terms of public expenditure per capita and the effect of this spending on the economy, it is interesting to observe current expenditure trends. After all, what counts are not the statistics of the past or what our neighbours are spending, but rather what we are actually paying and what we will pay in the future. We chose three periods to evaluate this trend: from 1985 to 2000-2001, from 1990 to 2000-2001 and from 1996 to 2000-2001.

Expenditures have doubled over a period of fifteen years, rising from 7.7 to 15.9 billion dollars, during a period when the population grew by only 10%. Over the last ten years, the average growth rate has been 3.5% per year, and for the last 5 years, has increased to 5.3% per year. The growth rate for the current year (2000-2001) is 7%.

The expenditure on the public health system, which includes contributions by users and third-party payers, has followed the same trend, consistently exceeding the GDP growth rates. During the same period, federal transfers paid under the Canada Health and Social Transfer (CHST) first grew until 1993-1994, then dropped sharply, and finally stabilized as of 1997-1998 onwards (Figure 8).

FIGURE 8 **Overall Change in GDP, Expenditure by the Public Health and Social Services System and Federal CHST Transfers, 1990-91 to 1999-2000**



Note: Public expenditure has been adjusted to take account of expenditures paid for by user fees, the operations of drug insurance plans and those funded by short-term borrowing to cover the net deficits of the network.

Sources: Ministère des Finances du Québec, 2000; Denis Bédard, *Le financement des soins sociosanitaires : une nouvelle étape possible dans la réforme du système*, Quebec City, January 2000; Canadian Intergovernmental Conference Secretariat, First Ministers' Meeting (Communiqué), Ottawa, September 11, 2000.

A number of explanations could be used to justify this growth rate. However, in the final analysis, the key point is that the growth rate of spending during the last years has clearly been higher than the GDP growth rate, while CHST transfers have decreased (Figure 8).

Economic Growth

The Commission wanted to project these trends for the coming years. Given that, over approximately ten years, the average and not the extremes must be used, the Commission hypothesized that the real growth of the economy will be 2% per year until 2010 and that the annual inflation rate will be the same for this period. It also examined the effects of these projected trends on public finances and on health services and social services, since the two are inextricably linked.

Based on our very cautious and conservative hypotheses regarding the increase in independent revenues, the evolution of federal transfers and the manoeuvring room essential to Québec's fiscal competitiveness, the government will not really be able to increase its total program spending by more than 2.4% per year, on average, for the next 10 years. The growth rate announced in the 2000-2001 Budget Speech is 2.9%, which is very close to our hypothesis. Moreover, this rate indicates that we are presently in a period of strong economic growth. The hypothesis of 2.4% corresponds to the 2% inflation forecasted, plus 0.4% to take population growth into account. It should be recalled that this average presumes that, during years of strong economic growth, the government could contribute slightly more, and that during difficult years it would probably contribute slightly less.

Expenditure Growth

To forecast health and social services expenditure, the Commission examined three hypotheses. The first was based on CPI growth plus 1.3%, or 3.3%, which was the average growth rate from 1990 to 2000-2001, including the years in which there were significant budget cuts. The second was based on structural cost increases, taking into account specific growth factors evaluated by the MSSS, which resulted in an annual growth rate of 5.1%, or the CPI plus 3.1%. This figure is similar to what has been experienced for the last 5 years. Finally, for simulation purposes, we considered an intermediate hypothesis of the CPI plus 2.6%, or 4.6%.

We thought it wiser to use the 5.1% annual growth rate as the most likely hypothesis for the next three or four years. On the one hand, it reflects the real situation of Québec over the last five years and, on the other, it is based on a more careful analysis of the current dynamics of growth in major expenditures. For example, it specifically takes into account items such as the budget for drugs and for the blood products supply system, the growth rate of which is much higher than the average. This was also the rate used by the other Canadian provinces during the last federal-provincial negotiations in September 2000. Finally, in its most recent publication, the CIHI noted that public sector health expenditure has grown by an average of more than 6% since 1996.[32]

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[32] Canadian Institute for Health Information, *National Health Expenditure Trends 1975-2000*, Ottawa, 2000.

It should be underlined that if a 5.1% growth rate is truly systemic and irreducible given current dynamics, and if the government granted an increase of only 3.0%, this would represent a recurring annual cutback of 460 million dollars. It would surely be difficult to make up the difference through increased productivity in a context in which there has been no major change in the basket of services provided or in the organization of services.

4.3.2.2 A BUDGETARY AND FISCAL CHALLENGE FOR THE GOVERNMENT

Given that taxation provides the bulk of necessary funds, what impact does this have on the budget of the Québec government and on our taxes?

In 1985, the Québec government devoted approximately 30% of its program expenditure to health and social services, compared with 35.3% in 1990 and 39.8% this year. We are therefore on a trajectory where the percentage of GDP devoted to public sector health expenditure is steadily increasing and, if no changes are made, there is nothing to indicate that this will slow down in either the short or medium term. This trend indicates that the government is inevitably spending less and less, in proportional terms, in all other sectors, such as education, the environment, transportation and social security, and more and more on health and social services. Furthermore, debt servicing, which is currently estimated at more than 7 billion dollars, reduces our capacity to spend on all programs due to its irreducible character and sensitivity to interest rates.

A projection based on the three hypotheses show that health and social services spending as a proportion of the Québec budget will increase relentlessly. Table 5 indicates that, based on our hypothesis of an annual increase of 5.1%, spending on health and social services would account for more than 50% of Québec government program expenditure by 2010-2011.

TABLE 5 **Share of Program Expenditure Allocated to Health and Social Services in 2010-2011(P)**

	2000-2001(P)		2010-2011	
Program Expenditure (2.4% growth)	$39,960 M		$50,952 M	
Health and Social Services Expenditure (% of Program Expenditure)	$15,899 M	39.8%		
- Hypothesis 1 (3.3% growth)			$21,997 M	43.2%
- Hypothesis 2 (4.6% growth)			$24,928 M	48.9%
- Hypothesis 3 (5.1% growth)			$26,109 M	51.2%

(P) Projection.

Source: Estimate by the Commission d'étude sur les services de santé et les services sociaux, on the basis of data provided by Claude Beauregard, ENAP, Quebec City, December 2000.

It is easy to see that if the government wants to improve Québec's fiscal competitiveness, limit the overall growth of program expenditure to 2.4% per year and not return to a deficit situation, the budget of all other governmental activities could not be indexed in the short term and would even decrease, in real terms, within a few years.

The overall finding is quite simple: the Commission observes that our debt level is the highest in Canada and that our taxes are the highest in northeastern North America. Moreover, funding from the Canadian government is being reduced. However, although our current level of health expenditure is not unlike that of other comparable states and countries, it has been increasing very rapidly for a number of years. The budgetary impact on all other government spending is quite pronounced and will become even more so in the foreseeable future if nothing is done.

Thus, unless higher economic growth results in an unexpected level of tax revenues sustained over time, the most likely scenario for the trend in health and social services expenditures, given the current dynamics, is that year after year it will swamp all other government priorities. This is an untenable situation for the government and, indeed, a critical problem for the overall operation of the state.

The current expenditure level thus appears to have reached a critical threshold and growth rate. In the absence of very tight overall management and the agreement of all the players, this inordinate growth could persist and destabilize all government activities, creating a backlash that could plunge the health and social services network into a deep crisis. It is therefore essential to review our choices and ways of doing things so that, together, we can get beyond this impasse.

To fully understand the situation, it should be recalled that, according to the experts, if a recession on the scale of the 1981-1982 recession were to occur, the government would have to drastically reduce its spending (i.e., by approximately 3 billion dollars per year) in order to continue to meet its zero-deficit goal. This would inevitably result in a proportional decrease of 1 billion dollars in MSSS expenditures. This example alone demonstrates the vulnerability of the tax-based funding of our services. Moreover, because of its weight within the government's budget, health and social services expenditure is one of the main challenges facing Québec's public finances, which are themselves inextricably linked to the North American economic environment.

THE SUSTAINABILITY AND INTEGRITY OF THE SYSTEM

R-19 In order to ensure the sustainability and integrity of health services and social services, the government and all citizens need to:

- **Recognize the vulnerability of funding that relies on taxation.**

To do this, we recommend that

- **The government establish one or more limits for the maximum acceptable public sector expenditure level;**
- **It introduce a triennial budget framework for the network.**

Obviously, the level of public sector spending on health and social services should concern all Québeckers and should be the subject of an ongoing and informed public debate. The National Assembly and its parliamentary committees should contribute to this exercise by finding a way to discuss this issue in a non-partisan way, in the public interest.

Managers in the network must be made aware of the fragility of the public funding on which the system relies and should manage accordingly. Similarly, managers of public finances must be very conscious of the risk to our system of unforeseen budget shocks that occur because of a poor understanding of the reality in which the network is evolving.

In the opinion of the Commission, a true partnership between the managers of public finances and the managers of the health and social services network can only be created by fostering a high level of transparency, clear objectives and a high level of predictability. Without these conditions, there is a high risk of destabilization, particularly during a recession, which would hurt both taxpayers and users.

The Commission believes that to avoid such a shock, the government should provide the network with triennial budget guideposts and then adjust them every year. The institutions should establish their base budget accordingly. A number of governments, including Holland, Catalonia, Finland and Denmark, provide such multi-year budget guideposts.

The government would also be well advised to maintain an up-to-date contingency plan, agreed upon with the network's main players, to deal with any serious public finance problem resulting from a recession. For example, this plan would propose alternatives both for the level and sources of funding, the allocation of resources, the payment of providers and, if necessary, for reductions in the supply of services.

Such a plan would have the advantage of providing the same information to everyone. We believe that this type of preparation would make it easier to deal with a crisis because everyone would know what efforts would have to be made. To simply believe that Québec's public finances are sufficiently solid to absorb shocks without any impact on the deficit or supply of services borders on illusion.

Similarly, the government should adopt appropriate measures to consult the network about the best use of any significant budget surplus, a portion of which could be devoted to health and social services. Historically, such surpluses have often served to absorb the deficits of institutions. This had the negative effect of not solving any structural problem in the organization of services and of indirectly encouraging the development of new services.

4.3.3 SOURCES OF FUNDING

In 1998, 73.4% of Québec's total health expenditure was paid for directly out of the state's budget. As shown in tables 6 and 7, this is higher than the average for the other major provinces and the Canadian average. The Canadian average is clearly higher than that of the United States but lower than in most European countries.

The relative proportion of public as opposed to private expenditures had been declining for a number of years, but the latest report by the CIHI shows that this trend has been reversed. This can also be seen to varying degrees in the other Canadian provinces. In 1998, public expenditure in Québec increased by 8.6%, compared with only 0.2% in the private sector. Recent announcements by the government lead us to expect a similar trend for 2000.

It is the Commission's view that there is no ideal percentage distribution between the public and private sectors, either for the various Canadian provinces or for different countries. Rather, the fundamental challenge revolves around the relevance, effectiveness and efficiency of spending in relation to the objectives set.

TABLE 6 **Public Expenditure as a Proportion of Total Health Expenditure in Québec, Canada and Other Major Provinces - 1960, 1975, 1980 and 1998 (In Percentages)**

	1960	1975	1980	1998
Québec	**27.0**	**78.8**	**81.5**	**73.4**
British Columbia	46.8	71.9	72.0	71.5
Canada	*43.1*	*76.4*	*75.6*	*70.1*
Alberta	48.5	76.9	77.2	67.9
Ontario	45.6	75.4	72.2	66.7
Québec-Canada Difference	**– 16.1**	**+ 2.4**	**+ 5.9**	**+ 3.3**

Note: The provinces are ranked in decreasing order of 1998 values.

Sources: Ministère de la Santé et des Services sociaux (MSSS), *La complémentarité du secteur privé dans la poursuite des objectifs fondamentaux du système public de santé au Québec, La présence du privé dans la santé au Québec*, Québec, 1999; Canadian Institute for Health Information, National Health Expenditure Trends 1975-2000, Ottawa, 2000.

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[33] Canadian Institute for Health Information, *National Health Expenditure Trends 1975-2000*, Ottawa, 2000.

TABLE 7 Public Expenditure as a Proportion of Total Health Expenditure in Québec, Canada and Major OECD Countries - - 1970, 1985 and 1998 (In Percentages)

	1970	1985	1998
United States	37.8	40.6	44.7
Italy	86.9	77.2	68.0
Canada	*70.2*	*75.6*	*70.1*
Québec	**66.9**	**78.8**	**73.4**
Switzerland	63.9	66.1	73.4
Germany	72.8	77.5	74.6
France	74.7	76.9	76.4
Japan	69.8	70.7	78.3
Denmark	86.3	88.2	81.9
United Kingdom	87.0	85.8	83.7
Sweden	86.0	90.4	83.8

– OECD = Organisation for Economic Co-operation and Development
Note: Québec and the OECD countries are ranked in ascending order of 1998 values.
Sources: Ministère de la Santé et des Services sociaux (MSSS), *La complémentarité du secteur privé dans la poursuite des objectifs fondamentaux du système public de santé au Québec, La présence du privé dans la santé au Québec*, Québec, 1999; Organisation for Economic Co-operation and Development, *OECD Health Data 2000: A Comparative Analysis of 29 Countries*, Paris, 2000.

The funding sources of the public system can be highly diversified, depending on the choices made by societies. In Québec, an examination of the principal sources of funding for public sector health expenditure shows that, in 1999-2000, 90.3% of this funding came from Québec's Consolidated Fund, which is funded by the taxes paid by Québeckers, either to Québec or Ottawa. Private contributions by users (e.g., supplements paid for private or semi-private rooms, fees paid by adults in residential centres and for pharmaceutical services) made up 7.6% of the funding and 2.1% came from various other sources (e.g., CSST, SAAQ, Department of Veterans' Affairs, billings of non-residents).

During its deliberations, the Commission examined various strategies for diversifying funding sources in order to cover increasing costs.

The first source considered was taxation. This source is fully made use of in Québec, which largely explains our higher taxes as compared with our neighbours. It is not surprising that the vast majority of those consulted rejected the idea of increasing taxes to finance growth in health and social services expenditures. At present, this source already provides approximately 14 billion dollars.

The second source considered was direct contributions by users. This source is used much less in Québec and Canada than in the vast majority of European countries that have systems similar to ours. Direct contributions, which mainly consist of contributions paid by adults in residential centres and supplements for rooms, amounted to approximately 564 million dollars in 1999-2000. In Québec, any additional use of direct contributions is generally associated with the idea of user fees, which runs the risk of undermining the principles of equity and solidarity in access to services.

The third source of funding considered was mandatory contributions to a public plan or group insurance plan similar to the drug plan. These contributions increased to 627 million dollars in 1999-2000. This source appears to be more acceptable to many of those consulted since contributions from the most disadvantaged citizens are paid by the state and everyone has access to the same basic basket of services. However, this funding method has been criticized because of the level of deductible and co-insurance for low-income individuals.

The fourth source of funding considered by the Commission was revenues from a capitalized insurance fund, financed by mandatory contributions. Few comments were made on this funding method, which is more complex and much less known. Nevertheless, some of those consulted were open to the idea, provided that the funds collected would not be used for other purposes. The possibility of services being sold to non-residents on a commercial basis by professionals and public institutions was also discussed, but received very little support. Currently this source of revenue makes up only a very marginal amount of revenues, based on special agreements. Finally, the Commission was also made aware of the fact that miscellaneous revenues from third-party payers represent approximately 300 million dollars.

TAX REVENUES AS THE PRINCIPAL SOURCE OF FUNDING

R-20 To consolidate public funding, we recommend that

- Tax revenues remain the principal source of funding of insured services;

To widen the coverage of insured services, we recommend that

- The use of various forms of collective insurance be explored;

To facilitate Québec's demographic transition, we recommend that

- The use of a capitalized fund be explored.

If we compare the sources of revenue of our system with those of other similar public systems, particularly in Europe, we find that taxation is the predominant source. In most countries with "Bismarckian" systems, such as France and Germany, or public systems based on general taxation, such as Sweden and Norway, social contributions, deductibles or direct generalized contributions are widely used in addition to taxation.

Funding that is based almost exclusively on taxation is directly subject to changes in tax revenues which are themselves prone to fluctuations due to domestic and international economic conditions. It is recognized that, during periods of recession, the pressure on health and social services expenditures increases. This is therefore a counter-cyclical effect.

We should therefore not be surprised if, as we have already seen in the past, this "counter-cycle" someday creates such pressures on public finances and on health and social services as a whole that the state suddenly, non-selectively and without warning "de-insures" services in order to balance its expenditures and revenues. The Commission is of the opinion that without a transition, this would leave a large part of the population without coverage since they are neither poor enough to take advantage of services for the needy nor rich or organized enough to benefit from private or collective insurance plans.

The other solution consists in broadening, temporarily or permanently, mandatory insurance plans like the drug plan, thereby making the costs related to coverage of specific services transparent. The Commission recognizes that this solution has drawbacks, for example, a more complex and probably more costly administration. On the other hand, it would offer universal protection of services for which the state provides little or no insurance. This is unquestionably preferable to simply de-insuring services.

Moreover, because of demographic trends in Québec, we must anticipate a rapid increase in the needs of seniors who have lost their autonomy, particularly those receiving long-term care, whether in the home or in a residential centre. This aspect will be addressed by a specific recommendation of the Commission. This is one more factor that will create increasing fiscal pressure on the revenues of working taxpayers within the next 10 years and that will continue for the following 30 years. The Commission believes that it would be socially wise to plan for this demographic transition by examining in the short term the possibility of creating a capitalized insurance plan specifically to cover the individual risk associated with the loss of autonomy and the collective risk of too much pressure on future tax revenues.

Finally, several Scandinavian countries, such as Sweden, Finland and Denmark, have implemented a modulated use of deductibles and co-insurance that respects the values of solidarity and equity with regard to those who are most needy. These options will surely have to be re-examined over the coming years.

4.3.3.1 THE FINANCIAL CONTRIBUTION OF THE GOVERNMENT OF CANADA

During the Commission's mandate, a new agreement on the Canada Health and Social Transfer (CHST) was reached between the provincial governments and the Government of Canada. Over the period from 2000-2001 to 2005-2006, the federal government will make additional cash payments of 21.1 billion dollars to the provinces.

The federal government also announced the creation of three funds: the Medical Equipment Fund ($1 billion), the Health Information Technology Fund ($500 million) and the Health Transition Fund for Primary Care ($800 million) (Table 8).

TABLE 8 Funding Commitments of the Government of Canada in support of the Agreements on Health Renewal and Early Childhood Development (In Billions of Dollars)

	Current Legislation				Beyond Current Legislation		Total New Cash
	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	
Canada Health and Social Transfer							
Amount of Current Cash Transfer (1)	15.5	15.5	15.5	15.5	15.5(2)	15.5(2)	–
General Cash Increase		2.5	3.2	3.8	4.4	5.0	18.9
Early Childhood Development		0.3	0.4	0.5	0.5	0.5	2.2
Total CHST Cash	**15.5**	**18.3**	**19.1**	**19.8**	**20.4**	**21.0**	**21.1**
Medical Equipment Fund	0.5	0.5					1.0
Health Information Technology	0.5						0.5
Health Transition Fund for Primary Care		0.2	0.2	0.2	0.2		0.8
Total Cash (3)	**16.5**	**19.0**	**19.3**	**20.0**	**20.6**	**21.0**	**2.3**
CHST Tax Point Transfers	15.3	15.8	16.5	17.2	18.0	18.8	
Total CHST Entitlements	30.8	34.1	35.6	37.0	38.4	39.8	23.4
Total Funding	**31.8**	**34.8**	**35.8**	**37.2**	**38.6**	**39.8**	**23.4**

– The CHST supports provincial and territorial programs in the fields of health, post-secondary education and social services.

(1) Current cash transfers include supplementary amounts planned in the 1999 budget ($3.5 billion) and in the 2000 budget ($2.5 billion).

(2) The current legislation is in effect until 2003-04. The base cash amount for subsequent years is $15.5 billion.

(3) The total amount of CHST cash and planned financing for measures not covered by the CHST.

Source: Canadian Intergovernmental Conference Secretariat, First Ministers' Meeting (Communiqué), Ottawa, September 11, 2000.

What this means for Québec is that after several years of decreases in the total amount of CHST, there will be some rectification. The evolution of financial transfers to Québec, including trusts under the CHST, from 1980 to 2005 is illustrated in Table 9.

TABLE 9 CHST Financial Transfers in Cash (Millions of Dollars)

	Québec	Ontario	Alberta	British Columbia	Canada
1980-1981	2,425	2,528	625	872	7,854
1985-1986	4,059	4,113	1,160	1,712	13,435
1990-1991	4,727	5,409	1,526	1,951	16,385
1993-1994	5,571	6,300	1,625	2,190	17,810
1998-1999	3,866	3,847	861	1,818	12,500
2000-2001	4,141	5,235	1,290	2,328	15,500
2003-2004	4,910	7,004	1,787	2,931	19,800
2005-2006	5,150	7,477	1,909	3,151	21,000

Source: Department of Finance Canada, October 17, 2000.

Thus, while rectifying the situation somewhat, this transfer will only amount to 5,150 million dollars in 2005 whereas it peaked at 5,571 million dollars in 1993-1994. The cumulative additional sums for Québec from new CHST investments are shown in Table 10.

TABLE 10 September 2000 CHST Cash Investment, 2001-2002 to 2005-2006 (On an Equal Per Capita Basis) (In Millions of Dollars)

	2001-2002	2002-2003	2003-2004	2004-2005	2005-2006	Total
Québec	667.8	853.9	1,014.5	1,149.9	1,283.9	4,970.0
Ontario	1,065.0	1,374.9	1,648.5	1,885.1	2,122.3	8,095.8
Alberta	276.8	357.4	428.1	488.5	549.2	2,099.9
British Columbia	372.3	481.4	578.8	664.5	751.8	2,848.9
Total – All Provinces and Territories	**2,800.0**	**3,600.0**	**4,300.0**	**4,900.0**	**5,500.0**	**21,100.0**

Source: Canadian Intergovernmental Conference Secretariat, First Ministers' Meeting (News Release), Ottawa, September 11, 2000.

TABLE 11 Medical Equipment Fund (On an Equal Per Capita Basis) (In Millions of Dollars)

	2000-2001	2001-2002	Total
Québec	119.9	119.2	239.1
Ontario	189.5	190.2	379.6
Alberta	49.1	49.4	98.5
British Columbia	66.2	66.5	132.7
Total - All provinces and territories	**500.0**	**500.0**	**1 000.0**

Source: Canadian Intergovernmental Conference Secretariat, First Ministers' Meeting (News Release), Ottawa, September 11, 2000.

As regards the three new funds, Québec will receive approximately 120 million dollars per year in 2000-2001 and 2001-2002 from the Medical Equipment Fund (Table 11). The Health Information Technology Fund, which is limited to 2000-2001, should provide Québec with a maximum of 120 million dollars in funded projects. Finally, the Government of Québec should receive approximately 35 million dollars per year for four years starting in 2001-2002 as part of the Health Transition Fund for Primary Care.

While this will improve the situation, the increase in CHST will not bring the federal contribution back up to its 1994-1995 level. A sizeable part of this contribution is made up by the CHST, but it also includes equalization payments and other programs, for example, services for veterans and for aboriginal communities. According to MSSS estimates, even when Québec's share of these funds is added in, the annual shortfall is still nearly 3 billion dollars, based on the prevailing funding rules in 1994.

It is up to the Government of Québec and the other provincial governments to decide whether the contribution level under the CHST is sufficient to meet the forecasted growth in health and social services expenditures over the coming years or whether there is a need to re-open discussions with the Government of Canada.

The Commission believes, however, that these funds are both too selective and too small to meet Québec's needs, and this is undoubtedly true for all the provinces. The Government of Québec should ask the federal government to invest at least five to six times more money, spread over a period of five to six years, to the following three priority areas. To support the transition of our system to a much higher level of performance, new medical equipment, the introduction of information technologies and the adaptation of primary care health and social services are essential. These needs, which are evident across Canada, will require tens of billions of dollars in investments over the next five or six years. Certainly the Government of Canada, failing an adjustment of cash transfers on the basis of the 1994-1995 program and indexed according to the increase in needs, at least has the responsibility to fund transition costs. We also believe that it should fund, based on the spirit of infrastructure programs used in other sectors, a similar plan to upgrade real estate holdings. Existing facilities, which are often obsolete and unsuited to new equipment, are in great need of improvement. The deterioration of physical facilities over the last ten years has been largely due to the financial disengagement of the Government of Canada.

AN INFRASTRUCTURE INVESTMENT STRATEGY

R-21 We recommend that under the Canada Health and Social Transfer agreement

- **The Government of Québec, in conjunction with the other provinces, propose a strategy for major investments in technological and medical infrastructures, information systems and fixed assets;**
- **Considerable resources be added to the level of primary care in order to adapt these services;**
- **Contributions be established over a five-year transition period, recognizing that it is the responsibility of the Government of Québec to establish priorities and administer the funds.**

4.3.4 METHODS OF ALLOCATING FINANCIAL RESOURCES

Methods of financial resource allocation, as well as the mechanisms for compensating and paying providers, must be consistent with the main objectives of the health and social services system.

The distribution of resources – including the allocation of financial resources to regions and institutions, as well as compensation and payment mechanisms for providers – is the most powerful and appropriate instrument that the state can use to change the organization of services and obtain the desired level of performance, at both the clinical and financial levels.

The Commission cannot emphasize enough the importance that should be paid to this issue by the MSSS and the Conseil du trésor, with the support of the entire government. A fundamental change in approach is in order. This change will be particularly demanding for the central authorities and the network since it challenges the way in which things have been done for the last thirty years.

Institutions must have information systems to find out what their costs are, by type of activity or episode of care or service, as well as what volumes of services they are actually producing. Second, the distribution of resources, through the allocation of budgets to the regions and institutions, and through compensation and payment of the players, must no longer be done on a historical basis, but instead according to the desirable organization of services, the needs of the population and the performance of everyone. If the government does not commit itself resolutely to this approach, it will have to invest more and more money in the system while still not being able to satisfactorily improve either the dynamics or the services provided.

4.3.4.1 ALLOCATION OF FINANCIAL RESOURCES TO THE REGIONS AND INSTITUTIONS

In Québec, resources are allocated to the regions and to institutions mainly on an historical basis. This is a method of allocation in "silos," first of all between the MSSS and the RAMQ, but also between regional boards and institutions. The regional boards have often drawn attention to the problems with this resource allocation method and asked for a more equitable approach, one based on real needs.

The Commission therefore advocates instead a conception of service organization that is "population-based," territorial and integrated. We propose the development of the means to introduce clinical and financial performance measures. We advocate that the hierarchical and bureaucratic vision be replaced by contractual relationships between the system's components, accompanied by client evaluation of the services delivered by providers.

Methods of allocating financial resources must therefore change. In the medium term, two things should be done: first, the envelopes of all levels should be integrated, thus ensuring more budget flow; and, second, budgeting should be linked to episodes of care and service, based on best practices and actual volumes. This will allow the gaps between institutions to be gradually eliminated, on the basis of their performance rather than on their capacity to consume resources.

Thus, within a few years, the budget of the regions should be allocated according to a weighted per capita method. In return, each region would be financially responsible for its population's consumption of services, regardless of the setting. Budgeting of primary care services at the local level should soon be done according to a "population-based" and/or territorial approach, if applicable, and based on the performance of service producers. Hospital and CHSLD budgeting should be done on the basis of care episodes, depending on their production volume and performance, and according to the orientations provided by the Comité sur la réévaluation du mode de budgétisation des établissements (committee to review the budgeting methods of institutions), chaired by Denis Bédard. In the very short term, several territories will be able to achieve budgetary flexibility by establishing unified boards of directors, thus eliminating the "silos" that result from resource allocation by institution.

It is also important to facilitate the "service purchasing" approach within the network itself, from primary care to secondary care and secondary care to tertiary care, in every situation where the concept can be introduced with the appropriate controls. This will contribute greatly to budgeting according to performance. It is therefore a desirable approach, particularly for the clinical teams of primary care integrated service networks, for CLSCs and all institutions that must establish service corridors.

4.3.4.2 COMPENSATION AND PAYMENT MECHANISMS FOR PROVIDERS

It is useful to remember that health and social services are provided by a huge labour force. More than 80% of the budget is spent on compensation.

It should be noted that the negotiation of the working conditions and wage conditions of all managers, unionized employees and health professionals is centralized. The strategic objectives of this approach are to better control the evolution of overall costs and to ensure that there is equity at the national level. It is generally acknowledged that these objectives have been achieved.

However, during the regional and national hearings, many managers and representatives of various organizations questioned the government's compensation policy for both managers and physicians as well as for unionized employees. The criticism did not concern salary levels, but rather all the "normative" elements which reflect a vision of how the system operates and are in themselves a compensation and payment system.

The Commission has not had the time needed to validate these assertions, but because they were made so frequently and were all along the same lines, we would like to bring this issue to the attention of the government. The central authorities are generally criticized for making up for lower salaries through compensation mechanisms centred on "agreement-based benefits" such as rigid work rules, but this relates more to the status of the unionized employee than to actual service delivery. The high cost of wage loss insurance and the CSST were also mentioned in Chapter 3. This way of operating is not highly compatible with the goal of improving performance.

In the opinion of managers, over the past years, this compensation mechanism has contributed to a rapid increase in the number of paid hours not actually worked, at the expense of hours actually spent delivering service to clients. For example, a survey of hospitals in the Montréal-Centre region revealed that between 1991-1992 and 1999-2000, the number of hours worked, that is, devoted directly or indirectly to service provision, decreased by 14.8%, as compared with only 9.1% for hours not worked. During the same period, the cost of hours worked decreased by 4.2% while the cost of hours not worked increased by 6.6%. In 1999-2000, nearly 30% of compensation costs were spent on hours not worked and fringe benefits. This percentage has been increasing regularly for 10 years. It therefore can be concluded that a large part of new money invested will not translate into services to clients. Another example is the absence of a true results-based compensation policy for managers. The incentive bonuses attached to results are very low and have little relation to the objectives of client satisfaction or financial results that measure performance. Thus, the managers of institutions that repeatedly run deficits actually receive incentive bonuses.

In the case of physicians, for a long time, fee-for-service and ceilings have been viewed as elements that are incompatible with current objectives and even less so with the objectives being proposed by the Commission.

All of these comments point in the same direction: a comprehensive, in-depth analysis must be conducted of all the mechanisms of compensation and payment of the players so as the ensure that everyone – physicians, managers and unionized employees – put more emphasis on their work, performance, productivity and the achievement of overall objectives.

REVIEW OF RESOURCE ALLOCATION METHODS

R-22 We recommend that

- **The MSSS and the Conseil du trésor review resource allocation methods in accordance with the objectives pursued in terms of the organization of services, productivity incentives and targeted results;**
- **They use a similar approach to adapt compensation and payment mechanisms for providers.**

4.3.5 THE *CANADA HEALTH ACT* AND ONGOING EVALUATION OF THE BASKET OF SERVICES AND MEDICAL TECHNOLOGIES

The current protection of health and social services stems from the concepts of hospital insurance, which was introduced in the 1960s, and health insurance, which dates from the 1970s. This protection is therefore dictated by history rather than by today's needs.

4.3.5.1 THE BASKET OF INSURED SERVICES

Québec's basket of insured health and social services results from an historical process, not an ongoing process of evaluation of the social or clinical relevance of services. It can be said that the basket of services, still strongly influenced by these concepts from the 1960s and 1970s, does not take social, demographic, epidemiological and technological change into account.

Moreover, to meet new needs, successive governments have created complementary, non-integrated programs. They have recognized a right to service within the limits of available resources under the *Act respecting health services and social services*. Today, this right serves as the grounds for legal actions, which clearly illustrates its lack of precision.

The result is that, as time goes on, citizens are less and less able to see the coherence of the basket of insured services. In principle, this basket is very broad, but in practice, limited budgets and waiting periods have sometimes made some services not very accessible. Citizens and politicians have formally rejected the idea of creating a two-tier system. In practice, resources that are too limited for a wide, poorly defined and often incoherent basket of services help to create confusion and grey areas.

In addition, the *Canada Health Act* and its regulations have not only decreed general principles on which there is still a broad consensus, but it has also determined the insured services. With time, however, it has become less and less suited to a modern interpretation of equity, solidarity and compassion.

For example, home care and ambulatory care are not covered, nor are drugs that can replace hospitalization, even if it costs less. Yet, any visit to the ER or to a physician for whatever reason is necessarily free whereas speech therapy for young children provided in a private health facility or rehabilitation centre is not covered. These are only a few examples of the inequities resulting from a law that has become outdated.

All that is needed are a few changes in the interpretation of this law in order to release the considerable sums of money that could be used elsewhere in the system and which would perhaps better serve the principles of equity, solidarity and compassion.

Another example, hostel services (meals, laundry, housekeeping) offered in hospitals, absorb more than 400 million dollars per year in Québec. How is it that these services are necessarily free for users, even though they generally stay in hospital for a few days, while adults lodged in residential and long-term care centres pay 275 million dollars annually for such services? Would it not be a better demonstration of solidarity, equity and compassion to allow for a contribution equivalent to the real costs of these services without depriving anyone of care or food, and by re-injecting these funds into other priorities? If these funds are viewed from another angle, 200 million dollars could be reinvested in the reorganization of primary care services, youth services and home care. Would this not be preferable?

The principle of "public administration" set out in the *Canada Health Act* has resulted in diagnostic and treatment resources being concentrated in the hospital in order to ensure that they are free of charge. Would it not be more logical and less costly to guarantee that these services are free rather than force physicians and users to enter the hospital via the emergency department simply to have access to free diagnostic tests, in the most costly setting?

The private production and management of publicly funded services has become commonplace in countries with a tradition that is at least as humanist and collectivist as Sweden and France whereas they are in fact illegal in the Canadian hospital sector.

The Commission did not have the mandate to propose a new interpretation of the five principles contained in the *Canada Health Act*. We would simply like to underline that the constraints imposed by this interpretation create real inequities and that it urgently needs to be reviewed. When, as a society, we choose a rigid interpretation, we also choose to allocate hundreds of millions of dollars to serve inflexible rules rather than to serve people who are ill or in need of psychosocial services.

4.3.5.2 NEW TECHNOLOGIES

The phenomenal development of new medical technologies and new drugs creates enormous pressure on costs. For example, without minimizing their beneficial effects, the continuous appearance of new drugs, the increased consumption of these drugs and the high price of many of them have resulted in an annual increase of 15 to 20% in the drug budgets of both group insurers and the public plan. The same trend can be seen in other areas. The appearance of diagnostic tools or treatment, which are increasingly sophisticated and costly, will make continuous and crucial ethical choices inevitable. A perfect example of this is the LVAD, which was presented in Chapter 1.

Choices are inevitable and they will undoubtedly have to be made along with the population. Citizens have the right to know exactly what is in the basket of services, rather than being left in the dark. They also have the fundamental right to obtain uninsured services here or elsewhere. To do otherwise would threaten the values of equity and solidarity between citizens. If services are covered more or less according to the type of service required, the setting, the individuals, the time of year, the hospital budget or the physician's ethical evaluation, they will sometimes be provided and sometimes refused, with no regard for their real effectiveness. This may be very expensive for the system and unfair for individuals.

It is therefore necessary to establish a mechanism that will facilitate objective choices and be in the public interest. These choices must be based on conclusive facts which take into account the values and resources of our society, effectiveness and the value-added of each molecule, treatment or piece of diagnostic equipment. This mechanism will have to maintain a healthy balance between individual interest and the public interest, through a system that remains generous despite limited financial resources.

Such a mechanism, which could most likely be introduced with the support of the Agence d'évaluation des technologies, the Conseil consultatif en pharmacologie (Advisory council on pharmacology) and other existing organizations, will serve to evaluate our basket of services and control the evolution of their costs. This should result in a more appropriate, higher quality and fairer basket of services.

REVIEWING THE BASKET OF SERVICES

R-23 We recommend that

- **The government adopt, by law, a highly credible mechanism, the goal of which would be to evaluate and continuously review the basket of insured services, new medical technologies and new drugs;**
- **It be composed of scientific and medical experts, ethicists and citizens who are recognized for their humanism.**

The implementation of this recommendation will draw on the sense of responsibility and public interest of our elected representatives, interest groups and, ultimately, of everyone. If we do not develop the capacity to make choices as objectively and calmly as possible in this matter, we are in fact choosing to continue to slide even further towards an arbitrary and ineffective system.

The Commission is conscious that, for this approach to work, changes in the *Canada Health Act* are required. These changes do not concern the five principles, but rather the need to adjust them to contemporary reality and to the financial resources available. During its deliberations, the Commission observed that, even though any change to this law is a taboo subject, in Québec as elsewhere in Canada, many public figures and organizations concerned about the sustainability of our system think that a debate should be held on this subject. The Government of Québec should participate by initiating this debate, which should be completely non-partisan and free of ideology.

4.3.6 MONITORING FACTORS IN THE GROWTH OF COSTS

The experts and citizens consulted by the Commission referred to a variety of causes to explain the rapid growth in spending. The Commission, without specifying the relative importance of each one, and knowing that they are interrelated, retained the following most frequently mentioned causes:

Certain factors are social in nature, for example:

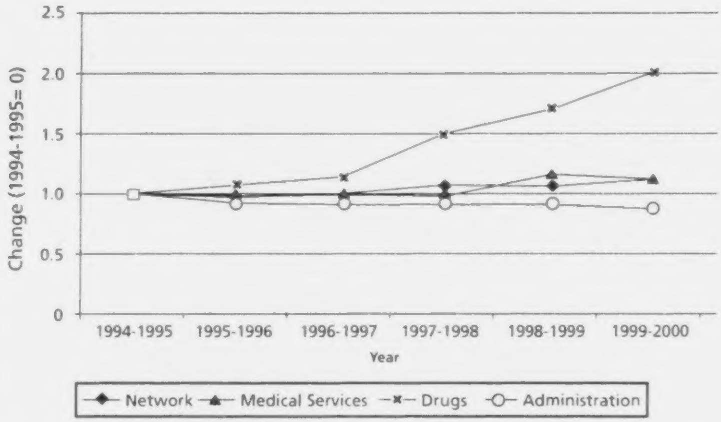
- Severe poverty, despite the context of economic growth;
- Accelerated population ageing;

Others are more "instrumental" or organizational in nature:

- The cost of drugs;
- The cost of medical technologies;
- The overall payment mechanism for managers, physicians and unionized workers;
- Budgeting and operating "in silos";
- The rigidity of collective agreements and absenteeism;
- Compartmentalization of professions and tasks.

If preventive management is adopted, these growth factors should be monitored very closely by the appropriate levels of government. However, the Commission was surprised to discover that the main factors referred to by everyone as contributing to the accelerated growth in costs are not monitored or controlled specifically, at either the national, regional or local level. Figure 9 illustrates the evolution of some of these main sets of costs. In brief, these growth factors are managed passively rather than actively.

FIGURE 9 **Change in Total Gross Expenditures of the Public Health System, by 4 Main Vectors, 1994-1995 to 1999-2000**



Source: Denis Bédard, *Le financement des soins sociosanitaires: une nouvelle étape possible dans la réforme du système*, ENAP, Quebec City, January 2000.

During the last decade, there has been a tendency to see the growth in costs as inevitable and therefore the measures taken to deal with them have often been radical and reactive in order to meet budget constraints. De-insuring, horizontal cuts which later resulted in deficits, and the mass voluntary departure program, are the most tangible results of a reactive rather than proactive management approach to quite predictable dynamics.

A MONITORING PLAN FOR THE PRINCIPAL GROWTH FACTORS

R-24 We recommend that

- **The MSSS and the Conseil du trésor adopt a specific monitoring plan for each of the main factors of growth in health and social services expenditures;**
- **They report annually on their findings and the action that has been taken.**

In the opinion of the Commission, at each level of management, these growth factors should be monitored regularly so that they can be better understood and controlled.

Taking the example of the growth in the cost of drugs, managers would adopt a plan of action which would include the following measures:

- Adjustment in the short term of the mandate of the Conseil consultatif en pharmacologie in order to strengthen the criteria based on cost-effectiveness used to list drugs;
- Intensification of programs for optimizing use of drugs;
- Establishment of independent information mechanisms and an on-line analysis of new drugs for diffusion to all physicians and pharmacists, regardless of where they practise;
- Information campaign targeted at the population;
- Cooperation with private insurers;
- Continuous review of the basket of insured drugs and the deductible rate according to objective and equitable criteria;
- Adjustment of the professional role of pharmacists.

By conducting an annual, public management review of this monitoring plan, on the occasion of the Budget Speech, for example, all managers and Québec citizens will be able to clearly see the decisions to be made in order to control the overall growth in costs.

4.3.7 EFFECTIVENESS AND EFFICIENCY

Throughout the consultations and hearings, the Commission received many suggestions on how, in the short, medium and long term, to save money and make gains in efficiency or effectiveness in the overall management of our network. As a general rule, these suggestions called for more operational flexibility and for stable management with real, strictly results-oriented manoeuvring room.

A PRIORITY ACTION PROGRAM FOR MANAGING THE NETWORK

R-25 We recommend that

> **The MSSS implement a priority action program aimed at achieving effectiveness and efficiency in the overall management of the network.**

Many of these suggestions, which were retained and discussed, are reflected in our recommendations. The following is a brief, non-exhaustive list of these suggestions, which, if applied properly, will have a positive financial impact. Also included are other suggestions from briefs received or presentations made to the Commission. They are also worthy of the reader's attention although they are not included in our recommendations.

4.3.7.1 RECOMMENDATIONS ALREADY DEALT WITH IN THIS DOCUMENT

Implementation of smart card and computerized, shareable health record

All the clinicians and the vast majority of consumers supported this project provided that confidentiality be tightly protected. Although the aim of this recommendation is to avoid delays, the multiplication of useless tests and wasting the time of both users and professionals, the Commission recognizes that its implementation would have a considerable financial impact.

Review of the budgeting methods of institutions

In all the regions and categories of institutions, the work of the Committee to review the budgeting methods of institutions, chaired by Denis Bédard, gave rise to interest in budgeting based on best practices, the characteristics of clienteles, activities and volume. This committee should work towards defining performance as well as designing tools to establish benchmarking measures that will be used to develop various budgets.

This strategic work will provide a powerful lever to develop information, management and performance indicator systems that are centred on results rather than on processes.

The establishment of unified boards of directors

The creation of unified boards of directors for defined territories with power over the budget flow and the local mobility of the workforce, would generate tangible gains in effectiveness and efficiency.

Accountability, accounting reports and performance contracts

The implementation of clear measures of accountability at all levels, of operating reports and of performance contracts are all elements that will have a significant, positive financial impact or that will free up precious time that can then be devoted to the needs of users.

The principle of subsidiarity in resource utilization

The use of the most appropriate and the least costly resources will increase the effectiveness of the system. In human resources management, the application of the principles of subsidiarity will allow services to be provided to the population at the best possible cost.

Implementation of an Info-Social system

Through a single, universal telephone "portal," distance evaluation and direct referral services in physical and psychosocial health services could have a positive impact on all social and health services, as is the case with Info-Santé.

The restructuring of support services

The proposal for a concerted restructuring of support services into autonomous services units should allow for the investment of substantial amounts and the reorganization of work that is both favourable to workers and conducive to efficiency.

4.3.7.2 OTHER COST-CUTTING MEASURES RAISED DURING THE CONSULTATIONS

Greater visibility of health and social services costs

The portion of income taxes that go towards health and social services should be indicated clearly on the individual tax return and a statement of services should be included in the future health card so as to make citizens aware of the cost of services.

Centralization of purchases

Parcelling out of purchases among a dozen regional corporations no longer makes sense. A central, computerized supply system, including delivery to points of service, would create substantial savings. Making a valid distinction between standard products and services (e.g., diapers, syringes, sheets and thermometers) on the one hand, and strategic equipment on the other, will surely result in savings.

Emergency room triage

Nurses who are trained, competent and authorized to carry out these tasks could speed up triage in ERs and, if applicable, refer people to medical walk-in clinics.

Membership in the Canadian Institute for Health Information (CIHI)

If Québec wishes to adopt a performance approach, it should join the CIHI. It is essential to measure services provided in comparison with other institutions in a similar context. Québec should even try to refine the international comparisons made by CIHI in order to better evaluate its own performance.

4.3.8 A POLICY FRAMEWORK OF PARTNERSHIP WITH THE PRIVATE SECTOR AND THE THIRD SECTOR

The Commission believes that the participation of the private sector – whether for-profit or non-profit – and of the community sector in the production and management of services should be re-examined as a possible complement to public sector production rather than from an ideological perspective. The production or management of services by private enterprises, independent professionals or what is being referred to increasingly as the third sector can easily be supervised by the state without in any way threatening public funding nor interfering in the internal administration of these organizations. This approach has proven to be beneficial in a number of Western countries as well as in Québec.

For example, 25% of CHSLDs are private and under agreement, physicians are almost all independent professionals and, throughout Québec, there are social economy enterprises that offer home care. All of them make a valuable contribution to our community.

In Québec and elsewhere in Canada, production and management of health and social services by the public sector is often contrasted with that of the private sector and the third sector. The production of services by either private, profit-making enterprises or by social economy enterprises or community organizations is often perceived as an open door to private funding of services or the removal of state responsibilities. All this creates a climate of confrontation which foreign experts generally find surprising. In most countries that have publicly funded health services, for example in Scandinavia and Western Europe, the level of public funding is often much higher than in Canada. But the contribution of private and third-sector enterprises is greater and is not really an issue. In reality, "non-governmental" production and management are more common in these countries and the co-existence of these three sectors of production of publicly funded services is generally seen as an asset.

A PARTNERSHIP POLICY FRAMEWORK

[illegible]-25 We recommend that

- **The Government of Québec adopt a policy framework of partnership with the private sector and third sector;**
- **This policy speed up the investments necessary to adapt services to the new realities and improve accessibility of services for everyone, regardless of their income.**

The Commission believes that it is time for Québec to adopt a partnership policy framework for health and social services, in particular, with the private sector and third sector. A number of parameters should guide this policy. Partnership with the private sector for the production and management of services must not be an opportunity for privatization of funding. Partnership must benefit all citizens at two levels: accessibility of services and reduction of the government's financial effort. It must also help improve the overall operation of the network. However, it is up to the public sector to control the quality of services and the application of all ethical rules. Partnership must also encourage the emergence of private, non-profit enterprises when circumstances allow. Finally, partnership must not be used as an opportunity to destabilize existing public sector jobs.

The type of partnership proposed by the Commission therefore does not have the profile often associated with the contracting out to the private sector of hospital food or laundry services. A proposal in this regard forms part of a recommendation for an investment "corvée."

Instead, we propose a partnership in developing areas, for example sectors that have considerable investment needs and/or where the supply of services must be adapted rapidly to technological, social and demographic change. These are all opportunities to improve services while at the same time contributing to Québec's social and economic development.

The participation of the private and third sectors in major public projects has already unquestionably contributed to the economic and social development of Québec. It is time to show that the health and social services sector is also a growth area for the overall development of Québec and that it should not be seen merely as an expenditure item. The public network, private enterprise and the third sector can contribute to this development.

4.3.8.1 INFORMATION TECHNOLOGIES

In the United States, the health industry devotes about 4% of its annual budget to information technologies, compared to 1% in Québec.

It will be necessary to make massive investments if essential productivity gains are to be made. If we want to reorient our network of institutions, managers and clinicians towards performance, the importance of developing information systems that focus on measuring results and not only inputs, as is the case right now, cannot be emphasized enough. Of course, these systems will have to rely on information technologies. Institutions need to be computerized for administrative and clinical purposes and also for sharing information with professionals in their own practices. The latter should be linked to the network. Finally, it is essential to introduce electronic health records and smart cards.

The creation of private-public consortia, or contracting out on a business basis, would accelerate the penetration of information technologies, decrease the investments required by the MSSS and institutions, and encourage these enterprises to export their know-how.

Moreover, the Commission found that the low level of investment is accompanied by obvious uncertainty in the leadership and coordination of the definition of needs and of the selection and realization of projects. Without pointing the finger at anyone, it must be said that, in the absence of sufficient budgets, of an operational management framework and a central authority that can make decisions and form partnerships, the institutions, regional boards and the MSSS have come to invest in a piecemeal fashion. It is therefore essential that the MSSS find a way to create a strong, flexible and accountable agent to manage projects in partnership with the private sector and coordinate the action of boards and institutions.

4.3.8.2 OPTIMIZING THE USE OF DRUGS

Québec's pharmaceutical industry is a leading sector owing to, among other things, the government's industrial policy in this field. The main criticism in this regard is that this policy could cost the RAMQ approximately 20 million dollars more per year.

The Commission recommends that the networks of integrated services, as proposed in Chapter 2, seek the participation of, and a financial and research partnership with, the pharmaceutical industry to increase biomedical research activity and also to promote and rigorously evaluate the best methods of organization, case management, drug use and support for caregivers.

The management, clinical and research communities as well as associations of patients and caregivers must join forces with industry. This public-private partnership in the pharmaceutical field will increase the number of therapeutic management projects that are cofinanced by the industry and the MSSS. This will make Québec a leader in the field of the optimal use of pharmaceuticals in health care. This will benefit health professionals and patients and improve the quality of services and cost control, as well as help to develop the pharmaceutical industry. The MSSS must not trail behind the industry but, on the contrary, must promote this approach in the clinical and research communities.

4.3.8.3 RESEARCH AND DEVELOPMENT

Like information technologies, medical technologies will undoubtedly develop at a lightning speed over the next 20 years. In a number of leading-edge sectors in Québec, university hospitals, universities and private enterprises have the potential to participate fully in this world-wide scientific and economic boom.

There is already a partnership between the public and private sectors, which must be given greater recognition and encouragement. This partnership is essential for keeping world-class research teams and clinicians in Québec so that they can train health-care professionals in highly advanced new technologies. A partnership approach that turns research results to good account through intrapreneurship will also contribute to the economic development of Québec.

In 1998, the production of 160 pharmaceutical product and medical technology enterprises reached 2.8 billion dollars and employed 12,100 people. Expenses on research and development for the pharmaceutical and biotechnological sectors, including university research contracts, totaled 570 million dollars and 5,100 jobs in firms, according to information from the Ministère de l'Industrie, du Commerce et du Tourisme (department of industry, commerce and tourism) alone. In the field of telehealth, there were 300 firms in Canada in 1997, with a sales volume of 350 million dollars and, according to the experts, this world market will reach 250 billion dollars US within the next few years.

There is therefore enormous potential for development in the fields of research, the optimal use of drugs, biotechnologies and information technologies applied to the health sector. According to the experts, Québec should aim to increase its industrial research and development activity by 15% annually in all health fields.

4.3.8.4 LONG-TERM CARE SERVICES

The Commission proposes that, in setting up networks of integrated services for seniors who have lost their autonomy, support and home care services for persons who have lost their autonomy as well as for those living in residential and long-term care centres be upgraded significantly. The current and future needs of seniors will increase very rapidly over the next few years and the supply of services will grow more or less steadily, depending on government policies.

In the last few years, a new sector, social economy enterprises, has emerged in the field of home care. The Commission believes that this formula, which combines the flexibility of the private sector with the humanist approach of community non-profit enterprises, should be promoted and supported while allowing fair competition with local and regional profit-making enterprises.

As regards residential resources, the Commission notes that the needs at various levels will also grow. The experiences of purchasing places in the private sector, the high standards of institutions recognized by the MSSS, the cost, flexibility and diversity of possible formulas as well as the analyses by the MSSS lead us to recommend that the CHSLDs be reserved for the clienteles with the greatest needs and that their budgets and equipment be adjusted accordingly. Most new places, with exceptions, should be created with the aim of developing healthy competition in the private sector on a contractual basis and for variable fixed periods.

We also note that it would be possible to encourage the emergence of private, non-profit resources at low cost if the state encouraged such solutions and local communities were involved in them. By proceeding this way, the state will ensure that there is an adequate and flexible supply of services without having to oversee their daily operation and without having to invest massively in construction. Finally, we believe that the CLSCs and regional boards are in a position to control the quality of these resources.

4.3.8.5 INDIVIDUAL AND COMMUNITY SERVICES PROVIDED BY THE THIRD SECTOR

The third sector is active in the distribution of services and also plays a leading role in defining the needs of the community. As a product of community dynamics, it is very sensitive to social and health needs. This sector jealously guards its independence, and with good reason. It is undeniably an effective partner in the production of services. The sector, which is multi-skilled and multi-form, is taking on an irreplaceable social responsibility in Québec's socio-economic dynamics.

> *"Community organizations are part of, along with social economy enterprises, volunteer agencies and other non-profit enterprises, what is increasingly being referred to as the third sector of the economy."*[34]
> *(translation)*

The third sector has developed rapidly in the field of health and social services during the last 20 years. Also, the appearance of the social economy projects following the 1996 economic summit was an important stage in this development. Currently, the social economy by itself generates approximately 3,800 jobs.

In 1994, there were "the equivalent of 13,200 full-time jobs"[35] in the network of community organizations. This means that, today, approximately 20,000 people working within what is called the third sector are making an essential contribution to the production of services, in particular for individuals and the community.

It should be underlined that the third sector is often the one that intervenes most at the level of health determinants, that is, relating to the social aspect of health, for example, the carrefours jeunesse emploi (youth employment centres), local employment centres, social reintegration enterprises and recycling enterprises. Moreover, the community network delivers a wide range of mental health services based on an approach that is most appropriate to and best integrated into the community.

The social economy is a major partner in home care without displacing jobs at the expense of CLSC employees. Thus, the social economy occupies a field of intervention and responsibility that does not involve the public insurance system. "In brief, in the field of services for individuals, the social economy model complements rather than duplicates the supply of services provided by public sector organizations."[36]

The Commission is therefore in favour of recognizing the overall contribution of the third sector to the stability of the health and social services system and its full participation in the life of the network. The Commission is aware of the importance of enhancing the mutual specificity of social economy enterprises, advocacy organizations, voluntary organizations and community organizations that maintain more formal links with the network in delivering services. All of these initiatives form a whole, a third sector, which plays an irreplaceable and structuring role. They should receive tangible recognition in the form of a renewed partnership through which the MSSS and its various government partners would take the measures needed for the partnership to flourish and mature.

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[34] Jean-Pierre Belanger, Conseil québécois de la recherche sociale (CQRS), *Les organismes communautaires, une composante essentielle de ce tiers secteur*, p. 89, Vol. 12, No. 2, December 1999.

[35] Idem.

[36] Y. Vaillancourt, Talk given at the opening plenary session of the colloquium of the Association de santé publique du Québec, 2000.

4.3.9 AN INVESTMENT "CORVÉE"

The health and social services network is falling behind in the areas of information and communication technologies, medical equipment, support equipment and maintenance of its real estate holdings. This situation is not unique to Québec. Indeed, for a number of years, most Canadian provinces have been considerably reducing their investments in the wake of the Canadian government's financial disengagement.

Although we cannot quantify precisely the capital expenditures that need to be made in these four areas, it is easy to see, based on a number of general indicators, that billions of dollars need to be injected over the next few years. It should be recalled that the construction of two new university hospitals in Montreal will alone require an investment of 2 billion dollars.

The Commission believes that a major investment program is necessary in order to preserve existing assets, decrease operating costs and increase the productivity of the system. Any delay now in investing these needed funds will only increase the amounts to be invested later, increase operating costs and gradually decrease the productivity of the system as well as the quality of services.

We are aware that, politically, such massive investments in equipment technologies and physical facilities may seem inappropriate given the overcrowding in ERs and waiting lists for certain specialized services. Our fellow citizens must understand that, to be effective, our professionals need to be equipped. We are also aware that the investment of 2 or 3 billion dollars within the next few years is a considerable sum for the Government of Québec. We are therefore proposing a catch-up plan based on a "corvée" approach, that is, a plan that relies on a variety of funding sources. This corvée should seek the involvement of the private sector, the unions (which have their own funds), health professionals, taxpayers, institutions, foundations and the governments of Canada and Québec. For each of the four priority areas, we will indicate who the partners in this upgrading should be. The objective is for 40% of the overall funding to come from the Government of Québec, 40% from the Government of Canada and 20% from "community" or private sources.

The sums provided for in the most recent federal-provincial agreement under the Canada Health and Social Transfer are clearly inadequate. We are confident that it is possible to convince the federal government to support the transition of the provinces' health care systems and to invest in modern infrastructures and the adaptation of primary care services. Many Canadian organizations, such as the Canadian Medical Association, have already suggested that the federal government make such a reinvestment.

A NATIONAL INVESTMENT CORVÉE

R-27 In order to upgrade the technological capacity and real estate holdings of the network, we recommend that

The Government of Québec launch a national investment corvée.

4.3.9.1 MAINTAINING ASSETS

In June 1999, Québec's Auditor General sent out a clear message on the need to review the network's real estate holdings. We must modernize our real estate management, adopt a more dynamic and preventive approach and optimize the use of the existing real estate holdings.

As most buildings are over 40 years old, their mechanical systems are often in disrepair and they are not very energy efficient. The adaptation of new diagnostic and information technologies and safety requirements for both the public and staff as well as minimal maintenance work give rise to needlessly high operating costs and create many headaches for managers.

An integrated approach to real estate management must allow capital assets to be maintained for future generations, provide an inviting atmosphere for staff and users, use an economic analysis of interventions focused on life cycle cost and promote preventive rather than curative management.

Based on the methodology recommended by the American Society for Healthcare Engineering of the American Hospital Association, the preventive management of the real estate holdings of the Québec health network, with an estimated replacement value of 10 billion dollars, would require the injection of 500 million dollars per year (Table 12). Yet, the triennial capital asset plan of the MSSS limits investments in this area to 100 million dollars per year.

TABLE 12 Preventive Real Estate Management Equation

Estimated replacement value of the real estate holdings of the Québec health and social services: $10 billion

X = annual operating expenses of installations (including major repairs)
2% of annual replacement value

Y = annual spending on functional adaptation needs (including improvements and changes)
1% of annual replacement value

Z = annual expenses for rehabilitation and replacement of facilities
2% of replacement value

X + Y + Z = $500 million

Source: American Society for Healthcare Engineering, American Hospital Association, 1997.

A five-year plan for accelerating investments must therefore be adopted, the cost of which should be equally shared with the Government of Canada. The Corporation d'hébergement du Québec (Québec housing corporation) should develop rules and standards for flexible financing so that action can be taken quickly and the program managed in conformity with the Auditor General's recommendations. Priority should be given to providing grants to clinical projects coordinated by the regional boards.

4.3.9.2 INFORMATION AND COMMUNICATION TECHNOLOGIES

The experts on computerization of the network appear to support structural investments for three main purposes: the introduction of electronic health records, linking physicians to the information systems of hospitals and CLSCs, and the integration of new applications into existing ones.

The Commission asked a group of MSSS experts to present the main priorities in computerizing the Québec health and social services system. In the opinion of these experts, six priority actions must be carried out within the next 10 years, requiring an investment of approximately one billion dollars.

The following priorities were presented by this group:

- *Equip institutions with a computerized internal communication network and information* systems of a clinical nature such as laboratory, radiology, a care plan and pharmacy plan. This would make it possible for professionals to share clinical information.
- *Establish infrastructures for accessing information and exchanging information between institutions, that is, national patient index, generic request-result tool, shareable health record, clinical information warehouses and national disease control registers.* This would be used to transfer a user's numeric data between institutions in the public network, clinics and physicians' offices, as well as to order and receive test results in real time. These would be accompanied by security measures throughout the network.
- *Create and secure communication links with physicians' offices by establishing a Québec health portal and by introducing the smart card.* This will link physicians to the public network and thus enable them to share available numeric data from laboratories, radiology and the pharmacy as well as information on care episodes, while respecting the wishes of users.
- *Introduce telehealth gradually* in order to improve access to specialized services and highly specialized services throughout Québec and to support professionals in the regions.
- *Establish priority national information systems* for managing and coordinating services related to blood banks, waiting lists and ERs determining the costs of services delivered in the network.
- *Complete the implementation of information systems in the social sector* which includes information on users and support the interventions of professionals.

The Commission was unable to evaluate the relevance and rationality of this entire analysis. It therefore can only support two proposals on which there seems to be a broad consensus, both among physicians and health professionals as well as representatives of patients and the population in general.

The first would bring together the network's main partners and patients' rights organizations to create all the conditions needed to begin to lay the groundwork for a computerized health record. While strictly respecting the confidentiality and security of the individual, this will make all the information needed for the management of each individual's health available to health professionals. Three years is a reasonable target for completion of this project to the satisfaction of both the population and network staff. The second proposal relates to investment: we believe that partnership with the private sector should be developed.

The sources of funding for many of the above-mentioned projects should come, in part, from the current budgets of the boards, institutions and hospital departments which already invest considerably, but without an overall plan for the network. This situation needs to be corrected in order to ensure that the main orientations and specifications for the establishment of a single, national, efficient and user-friendly system be respected and that local flexibility to make compatible choices be clear. Medical clinics should be given incentives to partly finance the equipment needed to be linked up to the network by computer. The Government of Canada should substantially increase its contribution under a new agreement aimed at accelerating investments and the Government of Québec should make it a priority to introduce the smart card and shareable health record.

4.3.9.3 SUPPORT EQUIPMENT (LAUNDRY, KITCHEN, CAFETERIA) IN INSTITUTIONS THAT OFFER HOSTEL SERVICES

Many of the people consulted by the Commission suggested that support services, mainly hostel services, be contracted out to the private sector. Those who support this proposal maintain that hostel services constitute a specialized field of activities which is not central to the mission of hospitals and long-term care facilities and that contracting out would therefore reduce costs. On the other hand, the public sector unions are strongly opposed to this proposal as a matter of principle and also to protect the jobs and wages of their members. They also dispute the advantages of the private sector and maintain that they are completely open to the reorganization of work in this area.

Given the immense investment needs in all, or almost all areas, it is very unlikely that this sector can be made a priority in the foreseeable future. Since most employees already have job security, the Commission believes that a major confrontation with the unions is unadvised. Furthermore, we are convinced that significant gains in productivity and quality can be made. We therefore prefer to seize upon the openness of the two major union confederations to make a proposal.

The MSSS, in collaboration with the Corporation d'hébergement du Québec and with the technical support of the Ministère de l'industrie et du Commerce, should gradually change these services into mixed enterprises of technical services at the local and regional levels. This would encourage institutions to transfer or lease their assets to these enterprises, subject to conditions yet to be determined. The major national unions would be asked to invest in them through their investment funds, in partnership with the Corporation d'hébergement du Québec. In a way, this would have the effect of giving workers' organizations, if not to the workers themselves, control over the required capital. The institutions would sign a service contract or a concession for a period long enough to make the investment profitable. These service contracts should not include exclusive service clauses, thus leaving the enterprises free to operate in the entire market. The Corporation d'hébergement du Québec could therefore inject new capital as needed to a maximum of 15 to 20% of the total. Its presence would also maintain a link with the government's pension and insurance plans and wage policies, where relevant.

Issues related to working conditions and work organization would be defined or negotiated within the enterprises, which should result in productivity gains. These gains could be reinvested or paid as dividends to shareholders – the government, workers' investment funds or the workers themselves. We are confident that the public sector unions will be able to get involved in such a process of change and meet the dual challenge of modernizing equipment and changing attitudes.

It is the Commission's view that such an approach, if introduced gradually, can only be beneficial. Under the aegis of workers' organizations, this would give a new impetus to the reorganization of work. Workers would be able to maintain their pension and insurance plans as well as their compensation levels while being provided with more modern equipment sooner. As a result, this sector would become more dynamic and productive, thereby decreasing its operating costs.

4.3.9.4 MEDICAL EQUIPMENT

The Commission proposes three main components of investments.

The first would be aimed at the acquisition of many small pieces of equipment for use in home care as well as small and medium-sized equipment for daily use in hospitals and CHSLDs.

Budget constraints in recent years have slowed down the acquisition of many of these small durable pieces of equipment which are used frequently and contribute to the productivity of providers as well as to patient comfort. The following are a few examples: information and communication equipment adapted to the work of home care nurses, electronic thermometer (approximately $500 each), syringe pump (approximately $700 each), a portable blood pressure monitor ($4,500), bladder scanner ($10,000), and electric bed (approximately $4,000). A "capital" budget allowance for investment in this equipment for several years would provide nurses and other caregivers with modern work tools. In addition to increasing productivity, this would send out the message that the difficulties faced by these workers are also of concern. The MSSS should not wait for other federal-provincial negotiations to be concluded but should implement this component very soon.

The second component would establish a triennial program for acquiring diagnostic and communication technologies for primary care services. This program would be designed to support the operation of the family medical network together with the CLSCs and physicians' offices.

To quickly put this family medical network into action, priority should be given to linking up the CLSCs and *Family Medicine Groups* within a network and facilitating their access to an appropriate technical support centre as a complement to the equipment already available in the territory. This second component should be funded by the two levels of government and by the physicians' offices, which would receive modern communication equipment at very little cost as an incentive.

The third component would focus on the acquisition of high-tech equipment, particularly in the CHUs, CHAs and institutes. The purchase of this equipment cannot be left to local initiatives or the outcome of struggles between stakeholders. An inventory of existing equipment first needs to be established, followed by a national acquisition plan.

It is also important to recall that most equipment almost always requires major construction work, training expenditures and workforce adjustment. Nor should we underestimate the additional operating costs created by the arrival of these types of equipment. Careful planning is therefore of major importance and the financial contribution of the Government of Canada is essential in order to speed up the modernization of this inventory of strategic equipment.

The equipment can be financed in a variety of ways. The Commission recommends that different solutions be implemented depending on the specific circumstances. Thus public-private partnerships may be possible and advantageous in certain cases.

R-28 In order to fund the rapid acquisition of high-tech equipment, we recommend that

The creation of a large foundation and the stimulation of existing hospital foundations in order to mobilize resources in support of a corvée to acquire medical technologies by means of tax measures.

We ask the government to create the *Fondation Québec Techmed*, which would help to keep Québec's specialized medical equipment up to date and prevent it from being haphazardly distributed. Despite the remarkable contribution of hospital foundations, the Commission believes that a large foundation capable of supporting all the needs of Québeckers would be useful and would help avoid costly fragmentation and duplication. In many cases, a partnership between hospital foundations, the *Fondation Québec Techmed* and regional boards will lead to large-scale, structuring investments in medical technology.

We propose that the Government of Québec inject 100 million dollars of initial capital and that, in accordance with the spirit of the corvée, health sector and business leaders aim to invest another 500 million dollars over a period of five years. To support the fund-raising campaign, a deduction of 120% of contributions would be granted during the next five years. This incentive would also apply to the foundations of institutions, but a threshold would be established so as not to detract from small foundations.

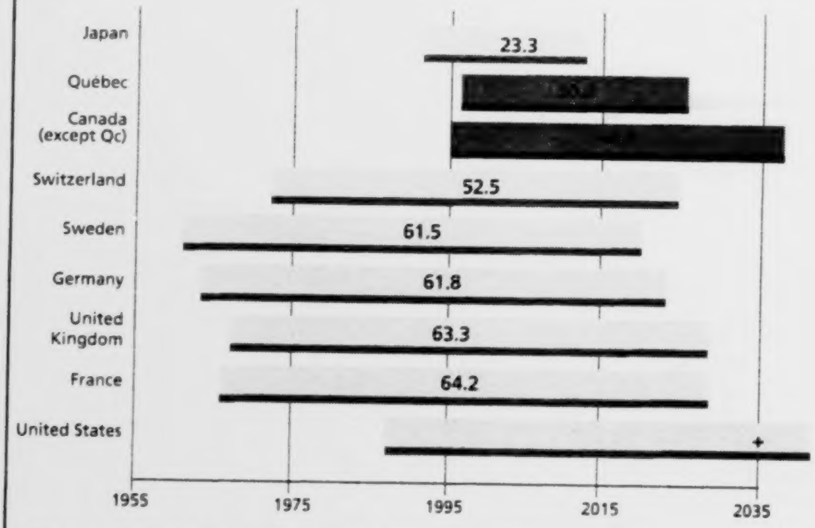
Through this strategy, community resources would be mobilized, expenditures by the Government of Québec would be avoided and an automatic tax contribution by the Government of Canada would be obtained. The latter would also be asked to contribute to the foundation and to increase the tax deduction for authorized contributions to 120%.

To conclude, the Commission believes that a strategy of a national corvée combined with the savings to be made over a five to eight-year period will make it possible for the Government of Québec, by recuperating part of the productivity gains made, to find all of the funds needed over the proposed period.

4.3.10 THE CREATION OF A LOSS-OF-AUTONOMY INSURANCE PLAN ON A CAPITALIZATION BASIS

The Commission was keenly interested in all of the issues related to the major demographic transition due to occur during the next few decades as a result of accelerated population ageing. This is part of the preventive management advocated by the Commission. It would be unwise as a society to adopt a wait-and-see policy when it is known that, like Japan, Québec will experience the most rapid demographic transition in the West (Figure 10).

FIGURE 10 **Transition from 12% to 24% in the Proportion of Persons Aged 65 and Over (in years)**



Source: Secrétariat du Conseil du trésor, Gouvernement du Québec, 2000.

Of primary importance is the fact that the percentage of the population aged 65 and over will have increased from 12% in 1996 to 24% in 2025. Even if this evolution is not in itself an insurmountable social, economic or financial challenge, we must prepare ourselves for the fact that the number of seniors will increase from 870,000 to 1,667,000 and that those aged over 85 will have increased from 77,000 in 1996 to nearly 200,000 between 1996 and 2021. The current profile of service consumption for these age categories is presented in Table 12, but it is likely that the situation will improve during the next few decades due to a variety of factors, such as better overall health, standard of living, knowledge level and new treatments. Nevertheless, it is obvious that the consumption of services by seniors, and especially by the very elderly, will still naturally be greater. It is therefore better to start taking this into account right away, both in planning how to organize services as well as how to fund them.

TABLE 13 Québec Government's Health Expenditure Per Capita, by Age Group, 1998 (In Dollars)

Age Groups	Hospitals	Long-term Care Centres (3)	Medical Services	TOTAL (1)
< 1 year	3,997	1	574	4,836
1-4 years	176	1	256	726
5-14 years	138	2	143	593
15-44 years	422	11	222	947
45-64 years	892	31	372	1,673
65-74 years	2,708	216	658	4,409
75-84 years	4,687	1,189	826	7,660
85-89 years	6,656	5,557	834	13,970 (2)
90 years and older	6,628	5,921	729	n/d
Average (all ages)	**930**	**141**	**315**	**1,761**

(1) Including expenditures for other professionals and drugs.
(2) 85 years and older
(3) Defined widely and may include long-term care units in hospitals and in rehabilitation centres.
Source: Canadian Institute for Health Information, *National Health Expenditure Trends, 1975-2000*, Ottawa, 2000.

The Commission has also found that Québec's health and social services system had already been experiencing difficulties in adapting to the needs of persons who have lost their autonomy, particularly seniors, to the detriment of both these persons and the operation of the system.

The Commission proposes the establishment of a family medical network based on the complementary services of the CLSCs and physicians' offices, which form the keystone in the deployment of networks of integrated services for seniors who have lost their autonomy. It will be difficult to do if the basket of services and home care remains poorly defined and incomplete, if access varies by territory and priorities of each CLSC and if residential care means being offered a place in a CHSLD, without any other alternatives.

To ensure that a network of *Family Medicine Groups* and networks of integrated services for seniors who have lost their autonomy are implemented throughout Québec, a number of conditions are necessary: the basket of home care services needs to be upgraded, alternatives to CHSLDs must be provided, the work of caregivers needs to be supported, local clinical teams must have real means to take action and funding needs to be structured and controlled in order to achieve desired results. In the Commission's opinion, it is an illusion to think that the major transition proposed can be achieved by the current system or by simply redeploying hospital budgets to home care.

A number of Western countries, including Austria (1990), Germany (1994), France (1997), Luxembourg (1999) and Japan have decided in recent years to take a comprehensive approach to the risk of long-term loss of autonomy by using collective plans for funding universal services. These plans cover home support services and home care as well as various residential and long-term care services. This is different from, but complementary to, medical and hospital services. In Québec, this is a rather new idea but many people within the government are interested in it and the reactions to presentations on this subject during the Commission's forums and consultations have generally been quite positive. A number of countries have decided to use this type of plan to provide insurance to cover the loss of autonomy related to any disability, regardless of age. Québec could also examine the possibility of covering losses of autonomy that are not already insured by the CSST or the SAAQ.

LOSS-OF-AUTONOMY INSURANCE PLAN

R-29 We recommend that

> **An insurance plan on a capitalization basis be created to cover loss of autonomy.**

The Commission therefore proposes the adoption of an insurance plan against long-term loss of autonomy which is adapted to Québec society. This plan will also support the organization of integrated service networks for seniors who have lost their autonomy, which were described in Chapter 2, and will complete the range of medical and hospital services that are currently insured.

The Commission proposes that such a plan be created because it will allow us to achieve several objectives simultaneously. It will help ensure that services provided at home or in residential care are equitable and sufficient throughout Québec. In addition, adequate funding of home care would decrease the costs and disadvantages of hospitalization and residential care in long-term care facilities. Such a plan would also provide recognition and support to caregivers if the person receiving care and the clinical team choose this alternative.

Capitalization would have the dual effect of guaranteeing the availability of adequate services for baby boomers in the future and reassuring the coming generation that it will not be crushed by the demographic and budgetary burden of the preceding generation. The government could therefore fix its budget contribution to these services at its current level. This is what Luxembourg did to make the evolution of the plan's costs more transparent and to adapt to this demographic challenge.

Finally, in order to gain the support of Québeckers, particularly the baby boomers, it is essential that the accumulated funds not be redirected for the purpose of covering the province's general expenditures. Citizens have very often cited the cases of federally administered employment insurance and Québec's automobile insurance as examples of a capitalized plan that simply serves to bail out the province. To protect contributors, the administration of this fund could be entrusted to the Régie des rentes du Québec (Québec pension board) or another Québec financial institution, on a non-profit basis.

By generally using competition to maintain a supply of services that is satisfactory both in terms of quality and quantity, the teams responsible for the use of financial resources would have the flexibility needed to promptly purchase the most appropriate services at the best costs and avoid, for a want of alternatives, having hospital emergency departments overcrowded with seniors who have lost their autonomy.

Although the Commission had neither the time nor the means to define this plan in detail, the following characteristics are suggested:

- The plan would be funded through a mandatory contribution based on personal income from all sources;
- The plan would be capitalized at a rate to be determined in order to decrease the foreseeable financial impact linked to the cost of these services for the younger generation;
- The accumulated funds for the benefit of contributors to the plan would be protected through means of solid legal mechanisms;
- The range of insured services would be well defined and would be oriented towards support for home care while at the same time offering various types of residential services;
- The operational management would be consistent with the Commission's recommendations regarding the *Family Medicine Groups* and networks of integrated services;
- The plan would cover long-term losses of autonomy (longer than 6 months or irreversible);
- Home care could be offered through benefits in kind or monetary benefits;
- Monetary benefits for home care would be determined, as needed, through the care plan. They would be non-taxable in the hands of the beneficiary or recognized caregivers, depending on levels and circumstances to be determined;
- The needs of persons will be evaluated according to a single scale in all CLSCs so as to ensure that eligibility is equitable;
- The management of the plan should give true responsibility to teams to purchase the most appropriate services at the best cost, taking into account the general situation, interest and preferences of the beneficiary and those of his family;
- Such a plan would insure all persons who have lost their autonomy in the long term or only seniors;
- Current budgets for home care and residential care and the resources from the new plan should be integrated;
- Management would provide the incentive to seek out the most appropriate resources.

4.3.11 FINANCING PRIORITY NEEDS: A FEASIBLE STRATEGY

There is no magic recipe for easily financing current services, priority needs and the transition to a new, more effective organization of services. Nevertheless, it is the Commission's view that a series of measures, large and small-scale, which are well orchestrated, could provide secure funding for the network and its adaptation to priority needs. The strategy proposed by the Commission can be summarized as follows:

- First of all, part of the annual increase in the overall budget of the MSSS must be freed up to provide leeway that can be used specifically for the reorganization of primary care services. Its size will depend directly on the level of annual increase in the MSSS budget and the capacity of the MSSS and boards to control the increase in costs attributable to secondary and tertiary care, which are concentrated in hospitals, the youth centres and rehabilitation centres. The idea is not to "punish" the latter; rather, the focus on primary care services goes hand-in-hand with this requirement to re-orient the budget.
- During the next 5 years, the government must create a "transition fund" to adapt the network, particularly the reorganization of primary care services. This fund would be created directly from budget surpluses from the two levels of government. The size of the transition fund will depend on the level of available surplus, but in all likelihood the governments will run surpluses again in the short term. They should take advantage of the favourable economic situation and immediately start to pay a portion of the surplus into a dedicated fund to ensure that the transition to a new mode of service organization is rapid.
- The corvée, or cost-shared investment program, should be self-financing through the partial recapturing of productivity gains over a period of 5 to 7 years following investment.
- The new loss-of-autonomy insurance plan will cover the cost increases related to most long-term care either at home or in a residential centre.
- The application of a mechanism for evaluating the basket of insured services and medical technologies will slow down the increase in costs. It is therefore urgent for it to be implemented.
- Partnership with the third sector and private enterprises will increase the services for individuals and the community, accelerate investments and decrease the use of public funds.

- Transparent monitoring of growth factors and an effectiveness and efficiency plan will slow down the growth in costs.

A GLOBAL STRATEGY FOR FINANCING PRIORITY NEEDS

R-30 We recommend

That the government adopt a strategy aimed at ensuring the financing of priority needs and the transition to a new, more effective organization of services.

During its deliberations, the Commission heard many pressing, and equally justified, requests for increases in financial resources. Meeting these requests would require an increase of several billion dollars in government expenditure, above the 5.1% growth rate. This, unfortunately, does not appear to be a realistic option in the current context.

Furthermore, if no measures are taken to change the present spending dynamics, which are a result of an outdated organization of services, the financial viability of the system will quickly erode. It is therefore important to give priority to investing in the reorganization of services and of funding methods in order to reorientate the current trend at a basic level and ensure that our system moves towards improved performance. In the current context, this will be as crucial as it is difficult.

The selection of priorities must be carried out very rigorously at all levels, should never reward lax management, and must meet both recognized priority needs and result in the overall improvement of the network's operation.

The Commission has retained a number of criteria that must be met in order to identify priority sectors. It must

- be a priority that is recognized by a broad social consensus;
- support the implementation of an organization of services that is more coherent, effective and efficient;
- contribute ultimately to reducing the pressure on public finances;
- allow all Québeckers to benefit from the investments, with a special concern for vulnerable clienteles;

- be compatible with stricter control of hospital budgets.

On the basis of these criteria, the Commission considers the four following sectors as having priority needs:

- restructuring primary care;
- home care and long-term care for persons who have lost their autonomy;
- services for young people with adjustment problems;
- upgrading the network's technological capacity and real estate.

Without going back over the explanations presented on the previous pages, we will summarize the logic of these choices from a financial perspective.

Reorganization of primary care services, in particular the establishment of a family medical network, is essential both in terms of the quality of services for all citizens and to control the costs of hospital emergency services.

The reorganization of basic services can only be accomplished with a structured supply of services and care in the home and long-term care for persons who have lost their autonomy permanently and who otherwise would end up in hospitals, which is very costly, and without appropriate services.

Services for vulnerable youth, particularly for young children, are crucial to avoid distress, suffering and marginalization of youths in difficulty, not to mention the exponential costs to society of each of these ruined lives.

Finally, the network's real estate and medical technologies are ageing rapidly. Also, information technologies are underexploited and are not used enough as levers to improve performance. It is the Commission's view that large investments must be made to increase the productivity of the network. The Commission also believes that meeting these priority needs will benefit the entire network and therefore all institutions and clienteles and that such an investment is financially feasible, but that it will be demanding for everyone.

ANNEX 2

GLOSSARY OF TERMS

A few definitions of commonly used terms are suggested to facilitate understanding of this chapter.

- **Public funding**: funding provided to producers of services, either public or private, by the consolidated revenue fund of the Government of Québec or the funds of government agencies with third-party responsibility (e.g., SAAQ, CSST).
- **Private funding**: funding provided to producers of services, either public or private, through charges paid by individuals, directly or through a collective insurance plan.
- **Public production**: production by a public organization that is, either primarily or exclusively, publicly funded and is directly accountable to a public authority, such as the Ministère de la Santé et des Services sociaux or a regional board.
- **Private production**: production by a professional or private organization, either for-profit or non-profit, that is either publicly or privately funded and is directly accountable to various public or private authorities (e.g., private CHSLDs under agreement).
- **Insured services as defined by the *Canada Health Act***: according to Section 2 of the *Canada Health Act* (Chapter C-6), this means "hospital services, physician services and surgical-dental services provided to insured persons...." "Hospital services" means "services provided to in-patients or out-patients at a hospital, if the services are medically necessary...but does not include services that are excluded by the regulations." No regulation of this type has yet been adopted. Physician services means "any medically required services rendered by medical practitioners." Surgical-dental services means "medically or dentally required surgical-dental procedures performed by a dentist in a hospital..." It should be noted that the concept of medically required services is not defined more explicitly within this context.

- **Uninsured services as defined by the *Canada Health Act*:** they include first of all according to Section 2 of the *Canada Health Act*, extended health care services, that is, "services defined in the regulations, provided for residents of a province, namely,
  (a) nursing home intermediate care service,
  (b) adult residential care service,
  (c) home care service, and
  (d) ambulatory health care service."

  These services have not been defined more explicitly by regulation. The financial contribution of Canada under the Canada Health and Social Transfer is granted both for insured health services and for extended health care services. Implicitly, uninsured services also include any other service that is not included in these first two categories (insured and extended health care services), whether they are funded or produced publicly or privately (e.g., physiotherapy clinic). An uninsured service can be provided free-of-charge in a province or can be subject to fees, as the case may be.

PART I

5

GOVERNANCE: CLARIFYING ROLES AND STRENGTHENING THE ACCOUNTABILITY OF SENIOR ADMINISTRATORS

5.1 FINDINGS

Over the course of our regional consultations and province-wide hearings, it became obvious that there is discontent regarding the governance of our health network. Situations at every level of the system were criticized. For example, local management teams and clinical teams feel that they are excluded from the major decisions that concern them. They believe that they are rarely consulted, even ignored, and deprived of power and control over their environment by national organizations from which they are far removed, like the MSSS, union confederations and institutional and professional associations, which are not very sensitive to their reality and over which they have little influence. For their part, the regional boards are accused of interfering in the internal management of institutions while the boards criticize these same institutions for bypassing regional decisions and at the same time trying to cut deals with the MSSS without taking into account the possible effects on the regional network of services.

Moreover, a number of people deplored the fact that the existing structures reinforce organizational "silos" and foster isolationism on the part of certain institutions as well as all too frequent "petty quarrels" between institutions responsible for serving the same territory. It is generally agreed that such situations are unacceptable, not least because it has been shown that the creation of multi-function institutions can result in considerable gains in terms of the integration and continuity of services.

Community organizations which provide direct services to the population emphasized the importance of their role as well as the need for adequate funding. Although they are open to the idea of accountability based on qualitative results, these groups would like the specific nature of their approaches and practices to be respected.

Moreover, many groups recognize that their strategies have negative effects and now deplore the fact that too many ad hoc, highly politicized decisions are taken at the national level under pressure from interest groups. They consider that the excessive media attention given to certain issues and the generalization of personal or local problems in fact works against objective analysis and decision-making based on the common good and good management.

The absence of a coherent and motivating vision of the goals and overall orientation of the system was also criticized by many people. The National Assembly and major organizations were sharply criticized for debating the daily problems of the network rather than the real issues that it must confront.

Some groups have even come to have serious doubts about the network's organizational structure. Given the crucial importance of the health and social services sector for citizens and its impact on public finance, more and more questions are being raised about the capacity of the MSSS to assume the triple role of leadership, management and control within the current structure. For many, this situation makes the MSSS vulnerable and reduces its ability to take action on fundamental issues.

In the Commission's opinion, what must be concluded from this is that the overall organization of the health and social services system has a direct impact on equity and on the effectiveness of the services provided to the population. The mechanisms put in place to provide governance are therefore essentially instrumental and must seek to equip the system with the means needed to achieve the targeted goals.

This is why any decision to modify the structures and mechanisms of governance must support the changes that are desired. It is also imperative that such decisions take into consideration the complexity and scope of the system. Recent experience shows that changes which are too sudden can have negative repercussions, both for the population and for the entire network. In this light, the Commission intends to limit its proposals for change to those that it considers to be crucial. We would like these changes to be introduced gradually so that they garner broad support.

5.2 GUIDING PRINCIPLES

The Commission proposes that the organization of primary care services be decentralized and integrated in line with a population-based approach. In our view, primary care organizations should develop contractual relationships with specialized and highly specialized regional and national institutions. We have stressed the need to define the responsibilities and accountability of the actors at each level. We have proposed a management philosophy based on performance, competence, initiative and the power to act, both for teams of professionals and for managers in the field. We would also like to see more cooperation between the players by using the method of contractual agreements that specify the results to be achieved, rather than a model focused on directives and regulations. The guiding principles that we present for the three levels of governance draw on this conception of the organization of services and this management philosophy.

1) Population-based responsibility

The MSSS, the regional boards, institutions and physicians' offices are jointly responsible for improving the health of the population and the organization of services. This responsibility is exercised in a given local, regional or national territory and includes the development of policies and their application as well as the organization and provision of services.

At its heart, the model of networks of primary care services is premised on responsibility for and follow-up of a specific population. A first level of responsibility is therefore exercised by primary care institutions.

2) Territoriality

The population-based approach is supported by territoriality. The territory should correspond as closely as possible to a geographically defined area in which a population, or a community, lives. This is a territory to which people feel they belong and with which the communities living there can easily identify and in which there are a number of institutions. In the regions, the local territory will generally correspond to territory served by the CLSC. In large urban centres, the local reference territory will be defined according to the proximity of services and will take into account the characteristics of densely populated urban environments. At the regional level, the territory of action will correspond to that of the regional boards. The national territory is Québec as a whole, which is the territory of action of certain highly specialized institutions that offer national programs.

3) Accountability: the primacy of results

The principle of accountability involves the obligation to account for one's interventions and the result of one's actions. Accountability is the corollary of responsibility and applies to all levels. Managing by results means agreeing to measure using modern performance indicators.

4) Subsidiarity: decision-making close to the action

The most important place for the citizen is where he receives the services that he needs. Other bodies only exist to support these sites, to ensure consistency among them and to orient the whole. The effectiveness of the entire system will depend primarily on the effectiveness of this first level. According to the principle of subsidiarity, decisions must be made at the lowest level possible within a hierarchy or an organization.

5) Management and performance

Management is an essential, not a secondary activity. It serves to organize resources with a view to taking action. Effective management requires strong leadership which cannot be exercised without clear governance, precise orientations, target results and genuine latitude in the means used to achieve these results. Good management is only possible if there is good governance and vice versa.

6) The participation of citizens

The democratic nature of the system is ensured by the involvement of citizens in the governance of establishments and regional boards. It is made concrete by the role of boards of directors on which citizens sit, and in the consultative committees where citizens are invited to express their needs, expectations and degree of satisfaction with services. These participatory structures should encourage both administrative and professional competence as well as community competence. What is important here is to involve the citizen.

5.3 RECOMMENDATIONS

5.3.1 NATIONAL GOVERNANCE

5.3.1.1 INTERNATIONAL CONTEXT

The role of the public sector has changed markedly in the last 20 years. The state's role in defining policies and general strategies in various activity sectors has been strengthened. At the same time, government authorities have withdrawn from operational activities

Today, the modern governance of states is carried out by departments that are increasingly sophisticated in terms of policy formulation, the establishment of objectives and the evaluation of results, whereas the administration of service delivery is entrusted to other public or private agencies. Indeed, Québec legislation on public service administration, which was adopted in June 2000, orients the entire apparatus of government in this direction. It is therefore expected that departments will be given a role that is recognized as central in all large organizations, that is, strategic planning for change, the control over and evaluation of all major processes. In so doing, departmental authority is increasingly freed from operations that are delegated to other levels.

The health and social services sector has not escaped this evolution and reforms have been carried out in many countries during recent years. In the area of governance, most countries have chosen to make a distinction between the role of policy formulation and the role of administering the delivery of services.

Thus, a number of states, including Sweden, Norway and Finland, have devolved more responsibilities to the municipal level. Others, such as New Zealand and Catalonia, have handed the operational management of services to separate agencies. In England and Alberta, regional levels of administrative authority have been introduced or consolidated, while in France and Germany, the "Bismarckian" model continues to be followed through the use of insurance funds.

Québec joined this international trend when it created regional boards in 1992. The vision underlying this reform was to create a regional authority that would be largely responsible for the organization and administration of services supply.

5.3.1.2 THE QUÉBEC CONTEXT

At a time when the health and social services network is facing all sorts of enormous challenges, national governance must also adapt in order to be able to provide our system with vision and direction. Good national governance is characterized, above all, by the capacity to make the best choices, to establish objectives and to measure results. It must also create the conditions necessary for effective management of the network, this very large, decentralized services enterprise, with the objective of achieving the continuous adaptation of its organization. Lastly, it must bring together decision centres and the people and the community that are affected by their decisions. By "national governance" we mean, in the first place, the Ministère de la Santé et des Services sociaux, which is both responsible to protect the health and welfare of Québeckers in the interest of the public and individuals, as well as the representative of the government responsible to the National Assembly. This national governance cannot be limited to a theoretical or abstract conception of ministerial responsibility. In reality, the notion of national governance entails the involvement of other departments, the political parties, the major national interest groups, and the media, which hold considerable power and do not hesitate to bring their full weight to bear in order to impose, in some cases, their vision, and, often, their particular interests. These daily power struggles complicate the task of those who provide or manage services at the local level and undermine the good general governance of the system.

A number of groups reproach the MSSS for having launched policies over the past decade, including health and welfare policies, without taking steps to ensure that these policies are monitored or evaluated. This lacuna is attributed to conflicting mandates, both between the boards and the MSSS as well as within the MSSS itself, and to a lack of continuity and stability in overall orientation due to the fact that the MSSS is being constantly thrown off balance by short-term crises.

The institutions in the network have created seven associations for themselves, the regional boards are joined together in a conference, the executive directors, senior managers and middle-level managers also have their own professional associations. Most of these associations have regional branches.

All of these organizations, other than the unionized ones, are also deeply involved in the affairs of the network and often intervene between the official levels of governance. In addition, they often act as quasi-decision-making bodies, behaving as if they possessed the political legitimacy to choose the orientations of the network, rather than acting as associations serving their members. This creates a situation that should not be encouraged by individuals and institutional members, and still less by the regional boards and the MSSS. According to the Commission, there are grounds to change the funding of these organizations in order to refocus their activities on the real needs of institutions to the benefit of the clienteles whom they serve. Finally, from the point of view of ethics and the healthy functioning of the system, it would be desirable for managers, institutions and their associations to adopt an attitude of partnership instead of one that is critical of authority.

The comments expressed regarding national governance are therefore not solely aimed at the MSSS. Some people even believe that the continuous pressure exercised on the MSSS by a sort of permanent state of crisis, often exacerbated by one or more interest groups and echoed by the media, makes the management of the MSSS an exhausting and perilous business. In this environment, planning the normal development of the network becomes next to impossible.

Crisis management is hardly conducive to detailed analyses, and it creates a dynamic whereby decision-making power is concentrated near the apex. Such a situation creates a number of risks. The first risk is that crisis management will become the normal management mode for the system, highly centralized and hierarchical, whereas most of the experts and international experience teach the need to decentralize, to bring decision-making power as close as possible to service provision.

The second risk is instability as a result of the turnover of the MSSS's senior managers, constantly dragged down by too many events outside their control. It should be remembered that in ten years, six different persons have held the strategic position of deputy minister at the MSSS, not to mention 22 assistant deputy ministers. It is hard to imagine how any large public or private firm could develop in a coherent fashion with so many changes in its senior management. It is not by chance that the Institute for Research on Public Policy recommended to Canada's first ministers, last September, that they promote more stability among the management teams in their departments of health.

The third risk is the loss of public confidence in the quality of health and social services. The gap in satisfaction that can be observed between those who have received services and others is, in this respect, significant: among the first group, more than 90% pronounce themselves satisfied, whereas only 60% of the second group consider the services to be satisfactory.

It should also be stressed that, despite a number of attempts to thoroughly redefine the mission, objectives and role of the MSSS, circumstances have not permitted the application of the best solutions presented after the reform of the early 1990s. In 1995-96, another effort to reflect on these issues was put in motion, but it was only partially followed up. Several branches have been redesigned and the organization chart of the MSSS has been changed many times, but more often in a short-term perspective than in a fundamental way. The Commission therefore considers that there is good reason for the government to undertake a detailed analysis of the mission, organization and operation of the national level of governance, represented especially by the MSSS, in order to clarify its dual mandate as regards policy development and responsibility for the general good functioning of the provision of services.

R-31 We recommend that

- **The government define precisely the role of national governance in a way that meets the contemporary political challenges of health and welfare and that frames the overall management of services on the basis of the principles advocated by the Commission;**
- **The change in the role of the MSSS emphasize the functions aimed at developing strategic directions, health and social policies and the evaluation of results;**
- **The government set up a task force with the mandate to provide advice on various options, particularly the renewal of the MSSS, the creation of a national agency, and any proposal aimed at making national governance more suitable to the challenges of the future;**
- **This task force be comprised of top public administrators, experienced managers from the business world, health professionals, and citizens.**

The work of such a task force should focus on, among other things, the following issues:

- the challenges related to strategic directions and political choices;
- the challenges related to the overall management of the network;
- the ideas proposed below in this report by the Commission.

5.3.1.3 CHALLENGES RELATED TO STRATEGIC DIRECTIONS AND POLITICAL CHOICES

Among all of the challenges of national governance, some are of an eminently political nature, in the sense that they require that the government take responsibility, in a judicious and considered way, for the welfare of the whole population.

A Consensus in the National Assembly

In order to ensure the long-term sustainability of our system, it seems crucial to establish, at the highest level of our democracy -- i.e., in the National Assembly -- a consensus reaffirming the attachment of Québeckers to the basic values of solidarity, equity and compassion that underpin our system. Many groups expressed the wish that a general statement to this effect be adopted as a declaration of principle that would inspire the whole governance of our system.

Such a consensus should also recognize the irreplaceable contribution of our services to the general development of our society, as well as the dignity that we recognize in the work of all those who provide services, whether directly or indirectly. We also believe that such a declaration of principles should recognize the need to make fundamental choices and to debate them in an open, ongoing and non-partisan way in order to ensure the future survival of our system. Finally, this consensus should also cover the need to require our network to become a world leader in performance, in return for a stable, transparent and predictable budget framework.

A Health and Welfare Policy

We believe that it is necessary to update health and welfare policy through a participatory and decentralized process, beginning with local groups and the persons working in the network, in order to make it, at one and the same time, a project for each territory and each establishment, and an educational process for the population. This would also be the occasion to align the development of the overall thrusts of this policy with the organization of services on the ground. During the Commission's deliberations, such a project was frequently mentioned as a unique opportunity to remobilize the staff of the system and to give a new direction to the organization of services.

Mechanisms for Evaluating the Basket of Services and Technologies

Accelerating technological development and the need to continuously evaluate the relevance of the basket of insured services will force all public systems to make choices in light of the limited resources of states. The Québec, Canadian and international experts whom we consulted were unanimous on this question.

To maintain intact the values of equity, solidarity and compassion, it is becoming urgent to define appropriate mechanisms for making choices, while at the same time making sure that scientific, medical and ethical experts, as well as citizens and elected representatives, participate. This enormous and arduous task has already begun in the most advanced countries and it is urgent to begin it in Québec in order to adapt the basket of services to changing needs and on an equitable and efficient basis.

The Modernization of the Five Key Principles of the *Canada Health Act*

The five key principles of the *Canada Health Act* clearly need to be modernized, without undermining the values of solidarity, equity and compassion which underlie them.

The rigid application of these notions, on the basis of an interpretation made by the federal government several years ago, ignores changes in modes of service delivery. This is recognized by a good number of Canadian experts.

Experts and highly qualified specialists are available in Québec to work with the MSSS to play a key leadership role and propose a contemporary interpretation of these principles. Because of its dynamism and a coverage of services generally much larger than that required by a strict interpretation of the federal legislation, Québec is well placed to promote this initiative to the other provinces and the federal government.

Interministerial Action on Health Determinants

Substantial improvements in health and welfare could be achieved through sustained and consistent action on health determinants. The MSSS should be responsible for a permanent, interministerial government action plan to combat the negative determinants. Québec showed its clearsightedness when it integrated health services and social services several years ago. It is necessary not only to preserve this "cohabitation," but to push it even further in the preventive management of the welfare of Québeckers.

In the rapidly changing world of health care, the MSSS has, moreover, the dual responsibility of upgrading our health and social services system and keeping citizens informed of the different issues so that they can play a role in public debates and choices.

Training, Research and Development

The issues in this area are enormous. The next quarter century will see an acceleration in the evolution of health sciences, medicine to pharmacology, from biotechnology to service organization, from the use of lasers to telehealth. It will therefore be necessary to orient basic, clinical and population-based research, as well as research on services, towards changing knowledge, public needs and Québec's major choices.

It is the responsibility of the MSSS to be vigilant, to be in the forefront as a leader in the consensus formation that needs to occur between the network, universities, CHUs, and industry to ensure that Québec takes maximum advantage of all of these developments. The Commission is convinced that it is entirely possible that leading-edge medicine, care and services can serve, simultaneously, our interests in having access to sophisticated diagnostic and treatment services and to be a lever of economic development in promising sectors.

5.3.1.4 CHALLENGES RELATED TO THE OVERALL MANAGEMENT OF THE NETWORK

The administration of service provision also presents formidable challenges.

Performance and Accountability

The vision and the major target results to be achieved are determined by the government. In order to achieve them, key indicators should be developed to evaluate the network's overall performance on a regular basis. Introducing a culture of excellence and performance also implies that evidence-based best practices should be promoted at the clinical and financial levels. We could draw on the experience of the creation of the National Institute for Clinical Excellence in Great Britain. The establishment of a well-structured yearly accountability mechanism would also give full meaning to government and parliamentary control over the system's ultimate purpose rather than its processes.

An Approach Based on Business Plan and Performance Contract

The sound administration of any large organization of services requires that multi-year strategic and budgetary orientations as well as yearly-updated business plans be adopted.

The Commission believes that the regional boards should adopt these orientations and business plans based on the expected results that have been conveyed and the financial resources available. These orientations should be expressed concretely through the signing of performance contracts centred on operational goals and indicators agreed on and evaluated every year.

This approach should help reinforce the adoption of managerial values and rules in the entire system and objectivize annual accountability reporting by boards to the national authority by indicating the mutual responsibilities of each level. The boards' implementation of a similar approach in institutions will require the same effort and contribute greatly to putting the network into an operating, management and accountability mode instead of one of demands and lack of responsibility.

Optimal Allocation of Financial Resources

The model of historical budgeting should be replaced by a model based on per capita weighting at the territorial level and based on the cost and volume of activities at the level of the institution. This long and painstaking process should gradually cover all categories of institutions and be conducted in a methodical and factual way.

The Commission considers that the allocation of financial resources to the regional boards and institutions so that they can implement government orientations, requires an environment of administrative rigour, since it is only under this condition that performance will truly strengthen equity. The Commission deems that it is administratively unacceptable that leaders of the boards or institutions negotiate for an increase in their budgets with the MSSS using media pressure. Only a rigorous method based on proven indicators will allow us to get away from this dynamic.

Restructuring National Programs

Given the size of the Québec population, many highly specialized services are available only at the national or supranational level. The acquisition and distribution of the most expensive medical equipment must be optimized to ensure that they are used to the maximum.

The major national programs, such as the Programme de lutte contre le cancer (program to combat cancer), or major national projects, such as the clarification of the mission and organization of institutions with a teaching vocation, the development of a ten-year project for CHUs, and the two large university hospital construction projects in Montréal, are all management issues that are crucial for the achievement of an orderly restructuring of our national services.

Adjusting Primary Care and Secondary Care Services

The implementation of the Commission's orientations on adjusting primary care and secondary care services will be a considerable operational challenge. Here again, the action of the boards needs to be supported and coordinated over several years for this new configuration of a family medicine network to emerge. This network will be properly linked to the renewed CLSCs, networks of integrated services (in particular, for those who have lost their autonomy), and effective service corridors, based on a contractual approach. The success of this implementation will depend on the continuity of orientations and on the quality and stability of management.

Computerizing the Network

Information systems should be developed to support clinical and managerial decisions, measure performance and assess results. Thus, institutions and professionals' practices must be computerized and linked within a network, and the health record, which is shareable through the smart card, must be implemented. All this involves massive investments in information technologies which will require that the definition of needs be tightly coordinated with the implementation of systems and equipment. Partnership with the private sector is both essential and promising, provided that these investment projects are managed in a true business environment that is transparent and the least bureaucratic possible.

Innovating Work Organization

Upgrading support services and technical services in institutions that have hostel services will require major adjustment in work organization. To successfully take up this challenge, it is necessary to create a relationship of trust between employers and employees based on win-win projects and a dynamic approach.

Streamlining the Bureaucratic Machine

The clarification of roles at the different levels of governance should result in better defined responsibilities of the players at all levels and thus reduce the risks of duplication which were often denounced before the Commission. Thus, the MSSS and the boards should substantially reduce their staff so as to compare favourably to similar public administrations.

5.3.1.5 A FEW AVENUES OF THOUGHT

Two approaches to the role, size and operation of the MSSS were suggested to the Commission. Although they appear to be quite different, both approaches aim at reinforcing the MSSS's leadership role with regard to fundamental health and social services issues and at moving it away from operations. Both approaches stem from the same desire to establish a coherent and sound overall administration of a three-level system and from the recognition of the importance of making politically informed choices and managing using a performance-oriented approach.

Renewing the MSSS

In 1996, a committee of experts was given the mandate by the then minister to examine the respective responsibilities of the MSSS, regional boards and institutions. Its report was tabled on December 9, 1996.[37]

In the Commission's view, these main proposals are still relevant today. Some twenty recommendations were proposed by this committee, aimed at renewing the MSSS so that it gives priority to its strategic role, eliminates duplications with the boards, develops key indicators and organizes, in a general way, performance evaluation and accountability. Several recommendations dealt with various aspects of the MSSS's internal operation, an in-depth review of the organizational plan and staff reduction. Among the committee's proposals aimed at clarifying the roles and accountability of the various levels of governance, those aimed at reducing MSSS's staff are still relevant today.

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[37] Deschênes, Jean-Claude et al., *Examen des responsabilités respectives du ministère de la Santé et des Services sociaux, des régies régionales et des établissements, réflexions et propositions*, December 1996.

An overview of official documents of different states shows that the ministries of health and social affairs of Finland, Norway and Sweden have 400, 330 and 180 employees respectively. It should be added that these ministries are supported by different agencies. In the Australian state of New South Wales with a population of 6.4 million, the ministry has 450 employees and coordinates 17 regional entities. Catalonia, whose population is also 6 million, created a Health Management Agency to administer 18 health services regions and its health and social security ministry has 565 employees. The MSSS 1999 Annual Report shows that it employs 660 public servants.

Creation of a Québec National Agency or Health Insurance Corporation

Is the departmental structure that we have had since 1970 still sufficiently appropriate for the current context to act as a principal governance tool in the overall administration of the supply of services? Should an agency or public corporation with a highly credible board of directors be created to coordinate the administration of the supply of services, in accordance with the orientations and budgets decided by the government, and thus free up the MSSS to develop policies, define standards and evaluate results?

Those who are in favour of an organic division between the functions of policy development and those of administration of the supply of services, believe that the challenges related to the development of policies, standards and evaluation will be so great in the next 10 to 15 years that it would be unrealistic to additionally entrust the same department with the responsibility to carry out sweeping changes in the organization and budgeting methods of services. Many maintain that there is a need to create a structure that is much more "operational," more flexible, lighter, and smaller in size. This structure would coordinate the action of the regional boards and implement the measures proposed for primary care and secondary care levels within a framework of strong regional autonomy and clear, properly formulated accountability to the level of national governance.

Others consider that this approach would facilitate the emergence of a new paradigm thus allowing, on the one hand, elected representatives to concentrate their action on the major issues and follow them up and, on the other hand, all the professionals in the network, their managers and workers to concentrate on the system's results and performance. They would thus increasingly become partners who are accountable as a group.

To further the consideration of this innovative hypothesis, the Commission would like to illustrate the possible profile of such an agency or corporation.

A Model of a National Agency

The creation of a Québec national agency, or health insurance corporation, would first require that the MSSS be given a national mandate that is similar in scope to that which exists in comparable countries or states, in particular in the Scandinavian countries.

Second, this would mean that 100 to 200 MSSS public servants would be brought under the RAMQ's administrative structure, which would be legally included in the new corporation. These employees would come from units that are more oriented towards administration, regional coordination and putting major programs into operation.

This human resources redeployment should be carried out with respect for the people involved and also with the aim of streamlining the heavy resources of national and regional governance, while clarifying roles.

The principal powers and mandates of this agency or corporation could be as follows:

- Allocate financial resources to the regional boards so that they can implement governmental and departmental orientations on health and welfare.
- Foster the integrated use of all human and financial resources at both the local and regional levels.
- Coordinate the regional boards in their gradual and continuous adaptation of the networks of primary care and secondary care services according to the major government orientations, in particular in relation to the operation of the family medical network and networks of integrated services.
- Establish every year, under the authority of the Minister, the agency or corporation's three-year strategic and budgetary orientations and the annual business plan based on the financial resources granted by the government and on departmental orientations on health and welfare.
- Establish every year the operational goals, performance indicators as well as the principal operational strategies for itself and the boards, and produce reports to the departmental, governmental and parliamentary authorities as envisaged in the *Public Administration Act*.

- Negotiate with each regional board a three-year performance contract related to the organization of services and financial results with an evaluation and annual accountability report.
- Manage the RAMQ's budget envelope and the various annual MSSS allowances in an integrated way so as to ensure budget flow and a gradually fairer distribution of financial resources to all the regions, based on a weighted per capita method.
- Negotiate on a long-term basis, with the medical federations and employee unions, the best ways to adapt normative clauses and work organization to two goals: meeting the requirements of continuous improvement of organizational performance and increasing staff satisfaction under existing agreements.
- Make recommendations to the MSSS regarding the appointment of regional board directors.

A board of directors composed of 11 to 15 persons, chosen from among the most eminent people in Québec society, and a president and chief executive officer would be appointed by the government to administer the affairs of the corporation in accordance with its incorporating act and government orientations.

This corporation would be a light organization which is highly operational, result-oriented and fully accountable, but which also has the means and sufficient legal and moral authority to introduce, concretely, a culture of excellence and performance in the organization and operation of services.

By giving such a task to a more "civilian" than "governmental" organization, all local and regional managers, health professionals and workers would soon realize that a transition is taking place, from a management paradigm in a government and political environment to an entrepreneurial paradigm of management and "civilian society."

5.3.2 REGIONAL GOVERNANCE

A characteristic of modern societies is the desire to bring the administration of public services closer to the citizens in order to adapt them to the latter's needs and expectations. The Québec health and social services sector was regionalized in the early 1970s with the creation of Regional Health and Social Services Councils (CRSSS). This trend was reinforced during the 1990s reform with the transformation of CRSSSs into Health and Social Services Regional Boards. The MSSS's advisory body thus became an entity which was accountable to its region and the MSSS with powers of planning, service organization and resource allocation in its territory.

This regionalization movement spread to all Canadian provinces, except Ontario. The Regional Health Authorities whose forms and mandates vary from province to province are based on the same principle, that is, giving the responsibility for organizing and sometimes managing the services to a regional authority. Even in Ontario, in March 2000 the Ontario Health Services Restructuring Commission proposed the following principle of governance: "Management should be located within regions or geographic subdivisions throughout the province, the definition of which is generally agreed (with the exception of the conurbation referred to as the Greater Toronto Area in which non-geographic divisions would be more appropriate)."[38]

The experts invited by the Commission pointed out that the approach to regionalization in the majority of European countries includes three levels of governance: a local level for basic services; a regional level which implements national policies taking into account the region's characteristics, and coordinates the regional supply of services; a national level which develops major policies, coordinates the regions and manages major national issues. In other words, the experts told us that, if the regional boards were to disappear, they would have to be replaced by another regional mechanism.

During its regional consultations and national hearings, the Commission also realized how much individuals and groups valued regionalization and, in particular, their regional boards. The board gives them a chance to be consulted and to participate in the decisions that concern them in their region. Every region is supposedly different and wants to be recognized as such.

Québec regional boards are not service delivery authorities nor are they political authorities. They do not have regulatory power nor an independent taxation power. The justification for their existence depends on their usefulness in society which is based on the political will to make a population responsible for the services they need and to associate citizens with decisions on these matters. Their usefulness also stems from their desire to avoid either being influenced by local interests alone, especially by the most powerful institutions, or being dominated by political interests of the time. The regional responsibility for service organization and resource allocation should improve the effectiveness of decision-making owing to a better understanding of the territory's realities. Lastly, the existence of regional boards should release the MSSS from operational responsibilities thus allowing it to fulfil its fundamental mission, which is to develop health and welfare policies, administer the major national mandates and evaluate results.

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[38] Ontario Health Services Restructuring Commission (March 2000). *Looking Back, Looking Forward: A Legacy Report*. Toronto (Ontario), p. 140.

Although few groups suggested that the regional boards should disappear, some asked that their number be reduced. Others pointed out the problem of certain territorial boundaries, for example Montréal, Laval and the northern and southern suburbs of the metropolitan region. Some raised the problem of a regional board cohabiting with a major institution which monopolizes a considerable proportion of the region's budget. Many criticized the composition and the method of electing members of the board of directors. The legitimacy of those elected was questioned since the rate of participation in elections is generally quite low.

The accountability of the elected boards of directors is ambiguous. Are they accountable to the population in their region through the intermediary of those who have elected them or are they accountable to the MSSS who provides them with orientations, finances the services and relies on them to implement programs and organize services in their region? This ambiguity was highly obvious during our visits to the regions. It is all the more present when there is actual confusion over the roles and powers of institutions, boards and the MSSS. The regional boards have the impression that decisions, which used to be made by them a few years ago, are now made by the MSSS.

The institutions can sense this and some think that it is quicker and more effective to go straight to "the top." The boards also have the impression that the MSSS and the Government no longer trust them to "settle problems," and consequently, the MSSS is becoming more and more involved in the direct management of institutions. The result is duplication and loss of credibility. Lastly, many individuals and groups deplored the bureaucratization and the cumbersome procedures in the regional boards.

The Commission studied various scenarios, that is, replacement of the boards with regional offices, and reduction of the number of boards to either 7 or 4. The regional offices approach was rapidly eliminated because, on the one hand, very few people recommended it, and on the other, it was deemed essential to maintain a balance between the regions and the central power in order to adapt services to the regional realities and promote equal access to services. Even though this is not a real decentralization, we consider that a devolution is preferable to a simple deconcentration. We have taken into account the current government policy which is aimed at giving back to the regions more control over activities involving citizens. As we observed, this political will of the regions is deep-rooted. Lastly, Canadian and international trends are moving towards regionalization, which results in an organization of health services and social services that is better adapted to the needs and characteristics of the population.

We rejected the scenarios that reduce the number of boards to either 7 or 4. Nevertheless, those who were in favour of simplifying management argued for this reduction, and it can be assumed that a different territorial distribution would have led to the creation of larger boards and a better balance between them. This would probably have eliminated the problem of institutions that are "too large" under boards that are "too small." We chose not to propose a change in the number of boards or in the territory of the boards, in the short term. The regional boards and the regions that they serve are the result of delicate political negotiations.

Moreover, despite criticisms made against the boards, the overwhelming view retained by the Commission is that they provide a setting for bringing citizens closer to decision making and allow them to exert influence on issues that affect them directly. This creates a real sense of belonging to this regional institution. Moreover, as they have shown in recent years, the boards can, as the result of their knowledge of the environment, effectively reorganize services in the regions, especially in times when resources are scarcer.

Given that, in recent years, structural changes have been difficult, we preferred not to stir up confrontations over this issue but rather to concentrate our efforts on inducing changes elsewhere, that is, changes in the conception of service organization, in the management philosophy, and in the ways and means of exercising governance. Moreover, with 16 regional boards and 2 regional councils, Québec is similar to other Canadian provinces and other Western countries.

However, if it is decided to keep the regional boards, they should be able to exercise the powers attributed to them, their responsibilities should be specified, their accountability should be clearly defined, and their results should be evaluated. We propose that the boards adopt the guiding principles suggested at the beginning of the chapter, both for their operation and relations with the institutions.

The changes that we propose in the organization of services and in financing will require a new leadership role for the boards and new organizational dynamics with the institutions and physicians' offices. It is up to the boards to initiate, support, facilitate these changes based on a more entrepreneurial than bureaucratic approach. The board must be confident in the ability and initiative of teams of professionals and managers at the local level and give them autonomy. The contractual agreement based on the evaluation of results must replace directives.

R-32 We recommend that

> **The MSSS confirm the necessity of regional boards that are responsible and accountable to it, that have considerable manoeuvring room and autonomy to implement departmental orientations in health and social services, organize services in the region and allocate resources.**

This recommendation is supported by 7 proposals:

5.3.2.1 REINFORCE THE BOARDS OF DIRECTORS OF REGIONAL BOARDS AND CLARIFY THEIR ACCOUNTABILITY

We believe that it is necessary to reinforce the boards of directors of regional boards and clarify their accountability link. Elsewhere in Canada and abroad, only a few regional structures elect members of the board of directors. In general, there is an election if the regional authority has a taxation power. Otherwise, members are generally appointed by the government, following consultation or on the recommendation of groups representing the population. This method of appointment allows citizens to participate in the decision-making process while clarifying the accountability link in terms of governance. It is also a means to ensure that the board of directors includes members who have administrative skills so as to be able to properly manage the hundreds of millions of dollars entrusted to them by the state.

To eliminate criticisms and conflicts about the legitimacy of members of the board of directors of regional boards and which are destroying the relationship of trust between the two levels of authority – national and regional – we consider that these members should be appointed by the government. However, precautions must be taken so as to avoid conflicts over roles and any form of partisanship which might discredit this regional structure in the eyes of the population. Thus, the following is proposed by the Commission.

P-47 We propose that

The board of directors of regional boards be composed of 14 members appointed by the Government, including:

- **4 persons recognized for their management skills and residing in different parts of the regional territory;**
- **3 persons recognized for their management skills from the health and social services sector;**
- **1 member of the National Assembly, but not a minister, chosen by National Assembly members of the region concerned according to a mechanism to be agreed on;**
- **1 person from the community sector;**
- **1 person from the education sector;**
- **1 person from the union sector;**
- **the president of the Regional Medical Commission;**
- **the president of the Regional Nursing Commission;**
- **the executive director.**

5.3.2.2 CREATION OF CITIZENS' FORUMS

P-48 We propose that

The board of directors of regional boards be responsible for creating a Citizens' Forum to give advice on the region's health and welfare issues.

The regional boards must encourage citizens to participate through modern means of information and consultation. It is the Commission's view that a Citizens' Forum chaired by the chairperson or vice-chairperson of the board of directors of the regional board should be set up in each region. This Forum would include 15 to 20 persons representing the point of view of the territory's citizens. The forum members would be appointed by the board of directors of the regional board from a list of names suggested by the users' committees, community organizations, union and socio-economic groups as well as health and welfare associations in the region. Adequate representation of age groups, health and social issues, gender groups and sub-territories should also be taken into account. Its mandate would be to organize public meetings according to the dynamic of each region and to advise and make recommendations to the board of directors on issues related to client satisfaction.

5.3.2.3 CREATION OF A REGIONAL NURSING COMMISSION

P-49 We propose that

The board of directors of each regional board set up a Regional Nursing Commission to give advice on the organization and integration of care in the territory.

This proposal is in keeping with the direction that we wish to give to primary care services. It assigns a greater role to nurses in the organization and provision of services through an interdisciplinary team. The Regional Nursing Commission and the DRMG will collaborate closely in order to support the harmonious deployment of medical and nursing staff and find adequate solutions to problems related to care delivery in the region.

5.3.2.4 REINFORCEMENT OF MANAGEMENT OPERATIONS

In order to support the regional boards in carrying out their mandate and to clarify their accountability, the Commission makes the following four additional proposals to reinforce their management operations.

P-50 We propose that

The regional boards adopt the Commission's guiding principles on governance, that is, population-based responsibility, territoriality, accountability, primacy of results, subsidiarity, importance of management, and citizens' participation.

P-51 We propose that

The responsibilities and accountability of the regional board to the central authority be expressed concretely in a three-year performance contract that is negotiated between the two parties and evaluated and adjusted annually.

P-52 We propose that

The regional board have the power to supervise and investigate the following cases:

- An institution that does not comply with the law and its regulations;
- An institution that tolerates a situation which could endanger the health and welfare of the persons served;
- An institution that is strongly suspected of embezzlement or of making serious management mistakes.

P-53 We propose that

The executive director be appointed by his board of directors subject to approval by the Minister.

To sum up, if the regional boards are to be kept, they should be able to really exercise their responsibilities and be accountable for them. They should also be able to sign performance contracts with the MSSS and institutions, and have the power to supervise and investigate. Otherwise, it would be better to consider abolishing them. The worst scenario would be to keep them and perpetuate the confusion about their role and responsibilities.

5.3.3 GOVERNANCE OF INSTITUTIONS

Many individuals and groups pointed out the confusion that reigns over the distribution of roles and responsibilities among institutions. In reality, the citizen in need of services wonders who is responsible for what among the CLSCs, physicians' offices, hospitals, CHSLDs, rehabilitation centres, and youth centres. He has the impression that the current structures support operation in "silos," petty squabbling and "conflicts between professionals." He finds the situation unacceptable and demands that this organization be "cleaned up," especially at the local level near him. Moreover, several groups showed us that, in grouping together institutions with different missions or in unifying their boards of directors in a given territory, considerable gains were made in terms of integration and continuity of services, and the exercise of governance was made easier.

It is hard for teams of professionals to find out who makes the decisions in the institutions. In the field of health, the non-medical professionals and managers told us that physicians make decisions which affect the organization of care, and consequently, the fiscal balance, but that they are not made accountable for this. The physicians, for their part, told us that they are not really part of the institution's decision-making process and feel "left out of the network." In the field of social services, teams are often grappling with the issues of division of responsibilities within the network and with partners outside the network, i.e., schools, childcare centres and community organizations.

Managers maintained that they are increasingly being robbed of their "field of management." Many major issues are discussed and decided on at the central level, often even operating details, such as collective agreements, agreements with the medical federations, agreements with managers, and requests for equipment. The regulation is becoming heavier and heavier and the number of directives is increasing. Members of the board of directors no longer know what their responsibilities are. Some told us that all they do is to approve decisions that have already been made. Many said that they have been elected or appointed to "defend" the interests of their institution, and not to develop a network, nor to maintain the fiscal balance. Executive directors no longer know whether they are accountable to their board of directors, the regional board or the MSSS. This confusion increases when responsibilities and accountability at the regional and national levels are not clear.

Several individuals and groups pointed out the problems of governing that are encountered when employees sit on the board of directors. There are conflicts over role which are detrimental to the board's smooth operation and which challenge the legitimacy of the board. Moreover, we were also told that the boards of directors must absolutely retain their clinical skills in addition to their management skills.

To sum up, the managers and professionals of institutions are demanding clear direction. They want to know under which authority they come and to whom they are accountable. They want the flexibility to manage and deliver their services and they want to be evaluated on their results.

We re-assert the importance of our guiding principles and hope that all the institutions will support them, i.e., "population-based" responsibility, accountability and primacy of results, subsidiarity, importance of management, and citizens' participation.

In accordance with the first principle, the raison d'être of the institutions and physicians' offices is to provide services to a population and to the individuals who make it up. The responsibility is just as individual as it is "population-based." Institutions and physicians' offices are jointly responsible for providing services to the population.

At the local level in Québec, this "population-based" responsibility will be carried out in a well-defined geographical territory. The territory in question corresponds to the reference territory for the organization of primary care health services and social services, in general that of a CLSC or RCM territory.

In the large urban centres, there are different notions of territory. What matters is that people can find their way easily. The regional board will have to organize its core of primary care services according to other factors such as demographic mobility, workplace, neighbourhood activity, existing networks and cultural and linguistic realities.

The guiding principles are meant to recall the vital role of the *Family Medicine Group*, CLSC and the local hospital as the primary setting where citizens receive services. This is where the basic activity takes place. The regional board should therefore give these players the freedom to act that is commensurate with their responsibilities. In return, the "producers" of services should accept the obligation to perform. This is why we propose that these obligations be negotiated through a performance contract between the regional boards and the institutions involved.

5.3.3.1 FACILITATE THE INTEGRATION OF PRIMARY CARE SERVICES

R-33 We recommend that

> **Primary care institutions be brought under one single authority in a given territory. This should include, within a unified board of directors, the CLSCs, CHSLDs and, if applicable, the local hospital.**

The Commission recommended that networks of easily accessible primary care health services and social services be set up for a given population. This change requires concerted action from all the players and institutions responsible for providing these services in their territories, in particular CLSCs, physicians' offices, CHSLDs, the local hospitals and community organizations.

To date, the unification of boards of directors of CLSCs and CHSLDs in several territories has yielded remarkable results, including concrete implementation of the population-based approach, better integration of services, better utilization of resources devoted to the administration, and increasing efficiency of institutions. We believe that this movement must be encouraged through a legislative framework that brings the boards of directors of institutions which deliver services to the same population closer together, on a territorial basis, where applicable.

Moreover, we believe that, in several territories, it would be possible to include the local hospitals in these unified councils, that is, those which group together family medicine and a number of basic specialties and only have a small number of beds.

We are not proposing a uniform approach to everything. The population's preferences and habits as well as the proximity of services should be considered. This model of unified board has already been implemented in several regions and has proved workable. The regional boards must draw on the model and seek to generalize it within 18 months. Elsewhere, attempts to bring boards closer together have met with resistance. Therefore, we think that, beyond this time period, the regional boards should be able to impose the unification scheme so as to achieve the expected results.

It is not a question of merging the institutions unless the parties all agree to this. In fact, the goal is to break the counterproductive logic of administering in "silos."

This recommendation is supported by 3 proposals:

One council of physicians, dentists and pharmacists (CMDP), one council of nurses (CII) and one multidisciplinary council (CM) per unified board

P-54 We propose that

A unified board should include only one council of physicians, dentists and pharmacists, one council of nurses and one multidisciplinary council.

The proposal would facilitate the adoption of a service-based approach to the population in a territory rather than in an institution. Since the CMDP has to recommend the obligations attached to the physicians' privileges, it would thus better respond to the needs of the territory covered by the unified board. Similar responsibilities could be given to the CII and CM.

5.3.3.2 PARTICIPATION OF PROFESSIONALS

P-55 We propose that

The unified board of directors be responsible for setting up a mechanism whereby all public and private health and social services professionals in its territory can advise it on the organization of services.

This mechanism for dialogue could take the form of a territorial council led by the chairperson of the unified board of directors that brings together the professionals working in institutions and physicians' offices as well as professionals in private practice: dentists, pharmacists, optometrists, physiotherapists, dieticians, psychologists, social workers, midwives and practitioners of alternative medicine.

5.3.3.3 RECOGNITION OF THE CONTRIBUTION OF COMMUNITY ORGANIZATIONS

P-56 We propose that

The institutions and regional boards

- **Recognize the vital contribution of community organizations, social economy enterprises and cooperatives in the health and social services sector;**
- **Define with the latter new methods to evaluate the results of their specific provision of services to the population.**

Community organizations, social economy enterprises and cooperatives play a vital role in the health and social services sector. Some are engaged in the field of patients' rights while others provide services which complement those of the network's institutions. These organizations are created out of the collective solidarity and the community's needs. They are enriched by their own characteristics and autonomy. When they provide services to the network and are funded by the network for these services, they must be responsible and accountable for their results.

5.3.3.4 COMPOSITION OF BOARD OF DIRECTORS OF INSTITUTIONS

R-34 We recommend that

> **Some members of the board of directors of local institutions be elected while others be appointed so as to increase administrative skills, to ensure that health and social professionals continue to work in the community and that citizens continue to participate.**

The unified board of directors of local institutions would be composed of 14 members, some of whom are elected by the population according to the process in force while others are administrators appointed by the regional board, but do not have an employment link or a contractual link with one or more local institutions, except for professional clinicians. A unified board of directors of a local institution would be composed of the following members:

- 5 representatives elected by the population, according to the process in force;
- 1 representative of the users' committee of one or more grouped or associated CHSLDs;
- 2 external administrators appointed by the regional board, residing in the territory and known for their experience and skills in governance;
- 2 external administrators appointed by the regional board, including one representative of the health professions and one representative of social services professions (these administrators should not be working for an institution);
- 1 physician from among the physicians in the local territory, appointed by the regional Department of General Medicine;
- 1 nurse among the nurses in the local territory appointed by the regional Nursing Commission;
- 1 person designated by the participants in the Territorial Council, if applicable;
- 1 executive director appointed by the Board of Directors.

5.3.3.5 FOSTER THE HIERARCHICAL ORGANIZATION OF SPECIALIZED SERVICES ON A REGIONAL AND NATIONAL SCALE

R-35 We recommend that

- Members of the boards of directors of regional-level specialized institutions be appointed on the basis of the following factors:
  - ❑ Links with primary care institutions and representation of the region;
  - ❑ Skills in governance;
  - ❑ Specific professional expertise;
- Members of the board of directors of institutions with national or supranational mandates be appointed on the basis of the following factors:
  - ❑ Links with the regional boards served;
  - ❑ Links with primary care and secondary care services institutions;
  - ❑ Skills in governance;
  - ❑ Links with the university: teaching and research (if applicable);
  - ❑ Specific professional expertise.

The Commission proposes that, with regard to access to specialized and highly specialized health and social services, a hierarchical configuration of services be set up and further integrated into the local, regional and national levels. It is our view that the regional board is responsible for defining clearly the role of regional-level specialized institutions and for determining, in collaboration with the institutions and groups involved, the mutual links, the "corridors" of services between the local and regional levels. However, we believe that the MSSS must take on the principal responsibility, with the participation of regional boards, for defining supraregional and national services and programs, as well as the mission of universities. As the same number of regional boards would be retained, the centrifugal forces of regionalization should be prevented from causing a scattering of expertise and highly specialized resources, which would result in a lack of critical mass, and problems related to the recruitment and retention of resources that might work against the survival of these services and programs.

Primary care health services and social services will only be effective if its links with secondary care and tertiary care are clearly defined and functional. These links, provided under a contractual agreement, must make it possible to clarify, among other things, the terms of referral, the type and frequency of services provided locally and, if applicable, the methods of information exchange, the training links as well as the conditions for participation in research and evaluation projects.

The composition of the board of directors of these specialized and highly specialized institutions must reflect these concerns. The Commission proposes that the majority of members of these boards of directors be appointed by the regional board and, in the case of university hospitals, by the Government and the university. The Commission's proposal for the composition of the board of directors of these institutions are shown in Annex 3.

5.3.3.6 INCREASE ACCOUNTABILITY AND EVALUATE PERFORMANCE

R-36 We recommend that

Three-year performance contracts be negotiated between the institutions and the regional board on the basis of shared responsibility and clear accountability for results to be achieved, and be assessed annually.

To respect the freedom of action and facilitate the budget flow that institutions need in order to provide services to the population, and to allow the regional board to fully assume its regional role of planning and organizing services, both partners must conclude a contract of commitment and performance. This contract would specify mutual commitments, define the responsibilities of each party, and the expected results, and identify the budget allocations and the indicators of performance measurement agreed on. These three-year contracts, which are updated annually, would provide the objective basis for accountability. In the case of national services or the mission of universities, the MSSS should be part of this agreement. The same principle of contractual agreement could exist between institutions at the different levels, with mutual responsibilities and accountability, and supervised by the regional board and the MSSS in the case of national services.

This recommendation is supported by 3 proposals:

P-57 We propose that

The boards of directors of institutions adopt the Commission's guiding principles on governance.

P-58 We propose that

The boards of directors of institutions set up a performance evaluation committee.

This committee would be responsible for evaluating accessibility to services, quality and continuity of services, client satisfaction and resource utilization. This responsibility could be assumed by the audit committees and the results of these analyses should be published in the institution's annual report.

P-59 We propose that

The boards of directors of institutions adopt effective and diversified means to consult and inform the population.

These consultations should deal with accessibility, quality, continuity and evaluation of services. Innovative approaches should be experimented with in order to reach individuals who have been reached the least through traditional means.

ANNEX 3

COMPOSITION OF BOARDS OF DIRECTORS OF INSTITUTIONS

General and specialized care hospital centres (CHSGS)

The board of directors of general and specialized care hospital centres should be composed of 13 members, including:

- Two persons recognized for their management skills and appointed by the Government from a list of names submitted by the board of directors of the regional board concerned;
- One person recognized for his management skills and appointed by the board of directors of the regional board concerned;
- One person appointed by the unified boards of directors of the region's primary care institutions;
- One specialist appointed by the board of directors of the regional board concerned on the recommendation of the regional medical commission;
- One nurse appointed by the board of directors of the regional board concerned on the recommendation of the regional nursing commission;
- One person designated by the proprietary corporation, if applicable;
- One person designated by the foundation of the institution;
- One person designated by the boards of directors of the regional boards served if the institution has a supraregional vocation recognized by the Minister;
- One person designated by the users' committee;
- Two persons co-opted by the directors, one of whom is from a health profession other than medicine and nursing;
- The executive director of the institution.

Psychiatric hospital centres (CHSP)

The board of directors of psychiatric hospital centres should be composed of 13 members, including:

- Two persons recognized for their management skills and appointed by the Government from a list of names submitted by the board of directors of the regional board concerned;
- One person recognized for his management skills and appointed by the board of directors of the regional board concerned;
- One person appointed by the unified boards of directors of the region's primary care institutions;
- One psychiatrist appointed by the board of directors of the regional board concerned on the recommendation of the regional medical commission;
- One nurse appointed by the board of directors of the regional board concerned on the recommendation of the regional nursing commission;
- One person designated by the proprietary corporation, if applicable;
- One person designated by the foundation of the institution;
- One person designated by the boards of directors of the regional boards served if the institution has a supraregional vocation recognized by the Minister;
- One person designated by the users' committee;
- Two persons co-opted by the members, who are from a health profession other than medicine and nursing and are not employed by the institution;
- The executive director of the institution.

Rehabilitation centres (CR)

The board of directors of rehabilitation centres should be composed of 13 members, including:

- Two persons recognized for their management skills and appointed by the Government from a list of names submitted by the board of directors of the regional board concerned;
- One person recognized for his management skills and appointed by the board of directors of the regional board concerned;

- One person appointed by the unified boards of directors of the region's primary care institutions;
- Two persons representing the professions in the field of rehabilitation;
- One person from the education sector appointed by the regional board concerned;
- One person appointed by the foundation, if applicable;
- One person designated by the users' committee of the institution;
- One person designated by the boards of directors of the regional boards served when the institution has a supraregional vocation recognized by the Minister;
- Two persons co-opted by the members and who are from community organizations operating in the field of rehabilitation and social integration;
- The executive director of the institution.

Youth centres (CJ)

The board of directors of youth centres should be composed of 13 members, including:

- Two persons recognized for their management skills and appointed by the Government from a list of names submitted by the board of directors of the regional board concerned;
- One person recognized for his management skills and appointed by the board of directors of the regional board concerned;
- One person appointed by the unified boards of directors of the region's primary care institutions;
- Two persons representing the professions in the youth sector;
- One person from the childhood and youth services sector appointed by the regional board concerned;
- One person appointed by the foundation, if applicable;
- One person designated by the users' committee of the institution;
- One person designated by the boards of directors of the regional boards served if the institution has a supraregional vocation recognized by the Minister;
- Two persons co-opted by the members and who are from community organizations operating in the field of rehabilitation and social integration;
- The executive director of the institution.

University hospital centres (CHUs), affiliated hospital centres (CHAs) and university institutes

The board of directors of institutions with a university vocation should be composed of 13 members, including:

- Three experienced directors appointed by the Government, including: one on the recommendation of the Minister of Health and Social Services, one on the recommendation of the Minister of Education, and one on the recommendation of the Minister of Research, Science and Technology;
- Three persons designated by the university concerned, including: one from the faculty of medicine and one from another faculty or school in the field of health (pharmacy, nursing, etc.). In the case of a CHA, one medical resident chosen by his peers practising in the hospital must replace one of the two persons from the faculty of medicine;
- One experienced director appointed by the board concerned;
- One experienced director designated by the boards of directors of the regional boards of the regions served;
- One director from the primary care services institutions;
- One specialist designated by the regional medical commission;
- One nurse clinician designated by the regional nursing commission;
- One person designated by the foundation of the institution;
- The executive director of the institution.

CONCLUSION

The Commission has made recommendations and proposals to improve the organization and financing of health services and social services.

Some of our recommendations and proposals are general in nature and require the commitment of the departments and the government to orientations and policies for the next decade. Others are more specific and can be rapidly implemented upon a ministerial decision and the creation of the conditions that will foster the emergence of change projects. To be implemented, many recommendations will require a close synergy between physicians, clinicians, professionals of institutions, and leaders of the regional boards and the MSSS. Some will require negotiations between the MSSS and the medical federations or union federations before being implemented. Lastly, several proposals will not require new money, some will need an implementation or transition budget, and a few will require a non-recurrent capital budget or an additional operating budget spread over the coming years to facilitate their implementation.

Regardless of the nature of the recommendations and proposals, the assertion of a vision and the ability to initiate and manage the proposed changes will be the deciding factors. As was seen in the past, the management of the change process in the Québec health and social services system is vital and highly complex. The aim of our proposed strategy is to initiate and manage changes underway instead of defining them in detail in advance. This strategy implies that the Government will rapidly and firmly take a position on the vision, the guiding principles, and the management philosophy that the Minister will propose as a result of the Commission's recommendations. Participants in the hearings and consultations have told us that they expect a direction and clear orientations from the MSSS.

They also want to take action. In our view, it is necessary to set up a three-year plan of action aimed at making the entire health and social services system evolve towards the desired direction. At the same time, the plan should make it possible to make a substantial number of proposals and implement them gradually, thus making the funding easier. Therefore, favourable conditions must be created to induce the principal players involved to support the orientations and adopt the direction of change. As the conditions become favourable, flexible details of implementation should be worked out. What must certainly be done is to decide, act, evaluate and adjust.

The time has come to give the network's managers and professionals some leeway to innovate and take the leadership needed to carry a great number of these projects of change to fruition.

To this end, we think that priority should be given to recommendations and proposals that are likely to create a new management dynamic in order to rapidly improve service delivery to the population and to restore the confidence to the staff who provide these services daily.

X

LIST OF 36 RECOMMENDATIONS AND 59 PROPOSALS

LIST OF 36 RECOMMENDATIONS AND 59 PROPOSALS

ORGANIZATION OF SERVICES: IT'S TIME FOR ACTION

10 recommendations, 32 proposals

PREVENTION: AN URGENT NEED

R-1 We recommend that

Prevention be the central element of a Québec health and welfare policy.

This recommendation is supported by 8 proposals:

Responsibility of players in prevention

P-1 We propose that the Government of Québec

- Recognize its responsibility and overall accountability for the population's health;
- Give the MSSS the mandate to coordinate the analysis of the impacts of the policies and programs of all departments and major government agencies on the population's health.

P-2 We propose that the MSSS

- Exercise strong leadership in health protection and promotion and disease prevention;
- Review health and welfare policy on the basis of the priorities identified at the local, regional and provincial levels, and by translating these priorities into means of action that institutions and professionals can adopt and implement.

P-3 We recommend that the public health departments

- Inform health and social services professionals about effective prevention practices;
- So that they can be integrated into their clinical practice.

P-4 We recommend that the citizen

Be made aware of his responsibility in managing his own health and be given access to information for this purpose.

Priorities in prevention

P-5 For children and youth, we propose

- Preventive services for pregnant women, new parents and young children (0-5 years old) living in an underprivileged environment;
- An education program for school-age children aimed at developing healthy lifestyles and appropriate social behaviours;
- A strategy adapted specifically for youth to prevent smoking and other addictions;
- A strategy aimed at preventing suicide among youth aged 12 to 18 years old;
- Wider accessibility to emergency oral contraception.

P-6 For adults, we propose

- An integrated program to prevent the main chronic diseases (cardio-vascular disease, respiratory disease, diabetes) including the development of healthy lifestyles among adults;
- The implementation of promotion-prevention measures and measures for early detection of cancer proposed in Québec's program for fighting against cancer;
- The implementation of the tobacco control action plan;
- The implementation of Québec's Strategy for Preventing Suicide.

P-7 For seniors, we propose

- A program of integrated preventive services aimed at:
  - improving their functional capacity and preventing the loss of autonomy,
  - improving lifestyles such as diet and physical exercise,
  - slowing down the progress of disabilities,
  - combating social isolation,
  - preventing injuries caused by falls,
  - increasing the safety of their own living environments;
- The improvement of programs for prevention, early detection and management of cardio-vascular disease, cancer, Alzheimer's disease, respiratory disease and disease of the joints and muscular-skeletal system;
- Programs to review the use of drugs and evaluate their therapeutic results.

P-8 To protect the entire population, we propose that

- There be more monitoring of
  - the quality of water,
  - the quality of air,
  - the quality of food;
- There be more monitoring of communicable diseases and diseases that can be prevented through vaccination: vaccination programs, surveillance of certifiable diseases;
- There be more monitoring of occupational risks
  - through systematic evaluation and management of work-related physical, chemical and biological stressors.

PRIMARY CARE SOCIAL AND MEDICAL SERVICES: THE FOUNDATION OF THE HEALTH AND SOCIAL SERVICES SYSTEM

R-2 We recommend that

- The organization of a primary care network constitute the main foundation of the health and social services system;
- This network be created on the basis of the current dual reality of CLSCs and physicians' offices.

CLSCs WITH A CLEAR MANDATE THAT INCLUDES AN ORGANIZED PRIMARY CARE SOCIAL COMPONENT

R-3 We recommend that

- The social component of this primary care network come under the CLSCs;
- The MSSS specify the CLSC's mandate in view of providing a minimum common set of basic services throughout Québec;
- The CLSC be responsible for providing the population in its territory with basic psychosocial services.

This recommendation is supported by 5 proposals:

P-9 For individuals asking for assistance, we propose that

The CLSC be responsible for providing and ensuring access to basic psychosocial services for any individual in its territory who asks for assistance for himself or his family.

P-10 For groups and individuals who are vulnerable or in trouble, we propose that

The CLSC be responsible for fostering and ensuring access to psychosocial services targeted at groups and individuals in its territory who are vulnerable or in trouble.

P-11 With regard to continuity of services, we propose that

The CLSC be responsible for managing continuity of the services provided to the vulnerable clienteles and individuals in trouble in its territory.

P-12 With regard to coordination, we propose that

The CLSC be responsible for coordinating the community resources required to respond to the needs of its population.

Increased investment in social research

P-13 To improve social practices, we propose that

The MSSS, in collaboration with the Ministère de la Recherche, de la Science et de la Technologie and its Conseil québécois de la recherche sociale, foster the rapid development of research on the evaluation of social practices and approaches and on the social determinants of health.

A PRIMARY CARE MEDICAL SERVICE BASED UPON *FAMILY MEDICINE GROUPS*

R-4 We recommend that

- The medical component of this primary care network be made the responsibility of *Family Medicine Groups* that include general practitioners working in a group, in an office or a CLSC with the collaboration of nurse clinicians or nurse practitioners;
- These Groups be responsible for a range of defined services for a population of citizens who chose these general practitioners.

This recommendation is supported by 2 proposals:

P-14 With regard to payment, we propose

- A mixed or blended system of payment for family physicians;
- A new contractual agreement system between the *Family Medicine Groups* and the regional department of general practice (DRMG) of the regional board;
- Service agreements between the *Family Medicine Groups* and CLSCs.

P-15 To support the implementation of *Family Medicine Groups* throughout Québec, we propose that

- A group be set up to support the implementation of a family medicine network;
- This group be led by a well-known family doctor; and
- That it be composed of clinicians (physicians, nurses, other professionals) recognized for their expertise and working in the primary care setting.

PROVISION OF BASIC SERVICES FOR YOUTH AND FAMILIES

R-5 We recommend that

- All Québec CLSCs be responsible for developing, with their partners, a common core of basic services provision for youth and families, and be accountable for it;
- This provision be implemented within the next 5 years.

This recommendation is supported by 5 proposals:

An authorized agent for youth services coordination

P-16 For the coordination of youth services, we propose that

Each CLSC or group of CLSCs appoint a person responsible for youth services to coordinate health services, psychosocial services and cross-sectoral interventions.

A review of the *Youth Protection Act*

P-17 So that children whose case was reported but not retained or who were considered not to be in a situation of danger after evaluation by the director of youth protection can benefit from adequate services, we propose that

- The *Youth Protection Act* be reviewed;
- The general protocol linking the youth centres and CLSCs in the territory be updated in each region;

A renewed MSSS-MÉQ agreement

P-18 For a cross-sectoral action that is further integrated with youth, we propose that

The MSSS-MÉQ agreement be renewed and that the Ministère de la Famille et de l'Enfance and the childcare centres also be included.

High quality standards for youth centres

P-19 To improve the services provided in youth centres, we propose that

Youth centres speed up their process of improving practices, defining high quality standards and training their workers.

A financial investment in "childhood and youth": a social priority

P-20 To consolidate the provision of basic services to children and youth, we propose that

Beginning in 2001-2002, the MSSS holds an amount of $20 million per year, for 5 years, in its future development funds.

NETWORKS OF INTEGRATED SERVICES FOR SPECIFIC CLIENTELES

R-6 We recommend that

Networks of integrated services be created, in particular for specific clienteles such as:

- The elderly who have lost their autonomy;
- Individuals suffering from serious mental health problems;
- Individuals affected by complex diseases which are often chronic.

This recommendation is supported by 4 proposals:

P-21 For the elderly who have lost their autonomy, we propose that

The regional boards initiate and supervise the creation of networks of integrated services and entrust the CLSCs with the responsibility for these, in collaboration with the *Family Medicine Groups*.

P-22 To ensure a quality of life for the elderly who have lost their autonomy, regardless of their place of residence, we propose that

- The provision and intensity of home care and residential care services be increased globally;
- The quality of services and respect for dignity be ensured, regardless of the place of residence and type of accommodation;
- Equality between the regions be ensured;
- A catch-up budget plan be developed so as to raise the intensity of care given to individuals living in CHSLDs to an acceptable level.

P-23 For people with mental health conditions, we propose that

- The basic mental health services be reinforced in CLSCs and the community network;
- On the regional board's initiative, networks of integrated services be created for people with severe and persistent mental disorders or affected by a severe mental illness;
- All these networks be under the responsibility of the institution which has the best experience and expertise to take on the leadership role.

P-24 For persons suffering from complex, often chronic diseases, we propose that

Networks of integrated services be set up with a view to sharing knowledge and resources between the national, regional and local levels.

COHERENT ORGANIZATION OF SPECIALIZED MEDICAL AND HOSPITAL SERVICES

R-7 We recommend that

The secondary care and tertiary care medical and hospital specialized services be consolidated on the basis of the following factors:

- Hierarchical configuration of medical services;
- Reorganization of emergencies;
- Affiliation of specialist clinics with hospitals;
- Clarification of the university's mission.

This recommendation is supported by 4 proposals:

P-25 With regard to the hierarchical configuration of services, we propose that

- The MSSS and regional boards recognize the principle of the hierarchical configuration of medical services as one of the foundations of the Québec health care system;
- The regional boards decide about the role of local and regional hospitals and their services, and designate their respective territories;
- The MSSS, after consultation with the regional boards, define the role and services of supraregional hospitals and designate them;
- Hospital budgeting include financial incentives for both the hospital and clinical department heads to encourage the negotiation of formal contracts of service "corridors" between hospitals.

P-26 To reorganize emergency services, we propose

The rapid implementation of measures envisaged in the *Projet Urgence 2000* (Emergency 2000 project) adopted in September 1999 and in the plan of action called *Relever ensemble le défi des urgences* (Let's take up the ER challenge) adopted in November 1999.

P-27 To improve flexibility in the provision of specialized services, we propose that

Specialists' offices or clinics be affiliated with a hospital and thus become the operational extension.

University hospitals

P-28 To adopt a modern vision of a network of university hospitals, we propose that

- An interministerial committee be created and composed of the ministers of Health and Social Services, Education and Research, Science and Technology, and be accountable to the Executive Council;
- This committee include experts from Québec and elsewhere in the world;
- This committee have the mandate to propose, in 6 months, a modern vision, for a 10-year period, of the organization of a university network (clinical, teaching, research and evaluation) in the field of health, and recommend the means to achieve it.

MORE RESPONSIBILITIES AND GREATER ACCOUNTABILITY FOR PHYSICIANS AND NURSES

R-8 We recommend that

Physicians and nurses participate more actively in the organization of care delivery and management, more specifically in the hospital.

This recommendation is supported by 4 proposals:

P-29 We propose that

A contract be signed between the physician and the head of his clinical department or service, thus formalizing the physician's appointment to the hospital by the board of directors.

P-30 We propose that

Specialists be paid according to the mixed payment system, based on the tasks that they must perform, as defined with the head of their clinical service or department.

P-31 To improve the hospital's medical-administrative management, we propose that

The clinical department head be entrusted with a greater role, a clear mandate, and be adequately remunerated.

P-32 To improve flexibility in the organization of care, we propose that

- The role of nurses practising in hospital and elsewhere in the network be enriched;
- Nurse practitioners be trained and gradually integrated through implementation projects.

MEASURES TO FACILITATE A BETTER DISTRIBUTION OF PHYSICIANS

R-9 We recommend that

- The MSSS reassert the importance of the physician as an essential partner in the delivery and organization of health services;
- It ensure that the organization of services be set up to facilitate the recruitment and retention of physicians, including the proposals in this report;

- It rapidly reach a consensus on the situation of medical human resources in Québec and develop a continuous and integrated medical staffing plan, in terms of general practitioners and specialists, promoting risk management rather than crisis management;
- It amend the law so as to better ensure the link between the physician's responsibility and accountability for the services that he provides to the population;
- The regional boards have the legal power to enter into joint agreements with the MSSS and medical associations, and have at their disposal a specific budget allowance (outside the payment agreements) to help solve the problems of recruiting, retaining and assigning medical staff;
- The MSSS and regional boards produce a report on the results of the distribution measures proposed one year from now and every year thereafter.

EFFECTIVE AND SECURE CLINICAL AND MANAGEMENT INFORMATION SYSTEMS

R-10 We recommend that

Effective and secure clinical and management information systems be implemented.

HUMAN RESOURCES:
DEVELOPING SKILLS, RESTORING PRIDE

8 recommendations, 14 proposals

TAKING ACTION TO COUNTER THE GLOOMY OUTLOOK OF WORKERS

R-11 We recommend that

The main players in the health and social services sector, in particular the Conseil du Trésor (Treasury Board), the MSSS, the unions, professional associations and corporations as well as institutions and the health-care facilities under their authority, recognize the urgent need to counteract the low morale and lack of motivation prevalent among staff in the health sector.

This recommendation is supported by 1 proposal:

P-33 We propose that

Each institution within the health system plan a business plan type of organizational project in which managerial staff, professionals and other employees join together to improve client services.

RECOGNIZING AND REINFORCING THE ROLE OF EXECUTIVE DIRECTORS

R-12 We recommend that

The Conseil du trésor, the MSSS and the regional boards fully recognize the strategic role of executive directors in the management of their institutions as well as in achieving national and regional objectives concerning service organization, the motivation of staff and financial performance.

This recommendation is supported by 2 proposals:

P-34 We propose that

Executive directors be given more room to manoeuvre and be held more accountable.

P-35 We propose that

- Their compensation be revised according to a comparative market analysis;
- A significant portion of their remuneration be tied to the results achieved by their organization.

PREPARING FUTURE EXECUTIVE DIRECTORS

R-13 We recommend that

The MSSS develop and implement a national program aimed at preparing future executive directors.

WORKFORCE PLANNING

R-14 We recommend that

- The MSSS, the regional boards and the institutions establish a permanent workforce planning process;
- They also set up a monitoring system, which would enable them to ensure the availability of a workforce that is sufficiently large and qualified to meet the needs of service organization.

This recommendation is supported by 5 proposals:

P-36 We propose that

The MSSS, together with the MÉQ, the universities and the regional boards, work to develop a permanent process for keeping track of needs in order to better anticipate the qualifications and staff numbers required to maintain the provision of services throughout Québec.

P-37 We propose that

The MSSS, the regional boards and the institutions develop mechanisms, such as orientation, continuing education, professional development, career-path assistance and retirement planning programs in order to respond appropriately to the evolving needs of the various groups of graduates that arrive.

P-38 We propose that

The regional boards actively support the steps taken by the institutions by providing coordination of local programs and implementing regional strategies aimed at recruiting and retaining staff, in accordance with service organization plans.

P-39 We propose that

Workforce planning become an integral part of strategic planning within each institution.

P-40 We propose that

Mentoring systems be put into place in the institutions to provide for the transfer of expertise.

MAKING SKILLS A PRIORITY

R-15 We recommend that

Staffing procedures be modified so as to make skills a top-priority selection criterion.

This recommendation is supported by 1 proposal:

P-41 We propose that

Continuing education and professional development programs be set up in every institution.

FOSTERING INTERDISCIPLINARITY

R-16 We recommend that

The framework within which health professionals practice be revised to create the conditions necessary for interdisciplinary work.

This recommendation is supported by 3 proposals:

P-42 We propose that

Teaching institutions adapt training programs designed for future professionals in the health and social services sector to fit with the new realities of the health system and with the demands of interdisciplinary work.

P-43 We propose that

The Groupe de travail ministériel sur les professions de la santé et les relations humaines (Departmental task force on health professionals and human relations) attach the utmost importance to breaking down barriers between the professions and to developing interdisciplinary work while ensuring the protection of activities that require a unique and complex level of competence;

P-44 We propose that

The Groupe de travail multipartite sur l'allègement de la réglementation (multi-party task force on decreasing regulations) foster simplification of the procedures governing professional corporations.

REINFORCING THE POWER OF LOCAL PLAYERS

R-17 We recommend that

The players concerned commit themselves to determining ways, at the local level, to take over matters related to the organization of work.

This recommendation is supported by 1 proposal:

P-45 We propose that

Players at the national level acknowledge that questions pertaining to work schedules, temporary replacement, attendance or non-attendance at work, and position management should be negotiated and ratified at the local level before the beginning of the next round of national negotiations.

REDEFINING MOBILITY

R-18 We recommend that

The parties concerned come to agreement on a new definition of the notion of mobility, one which is better adapted to the recommended service organization.

This recommendation is supported by 1 proposal:

P-46 We propose that

Union organizations undertake, locally, to agree on a set of rules which would allow for the mobility of staff between affiliated bargaining units and, when applicable, between institutions serving a given population.

PUBLIC FUNDING:
STRENGTHENING SOLIDARITY THROUGH PERFORMANCE

12 recommendations

LEVEL OF FUNDING

R-19 In order to ensure the sustainability and integrity of health services and social services, the government and all citizens need to

- Recognize the vulnerability of funding that relies on taxation.

To do this, we recommend that

- The government establish one or more limits for the maximum acceptable public sector expenditure level;
- It introduce a triennial budget framework for the network.

SOURCES OF FUNDING

R-20 To consolidate public funding, we recommend that

- Tax revenues remain the principal source of funding of insured services;

To widen the coverage of insured services, we recommend that

- The use of various forms of collective insurance be explored;

To facilitate Québec's demographic transition, we recommend that

- The use of a capitalized fund be explored.

R-21 We recommend that under the Canada Health and Social Transfer agreement

- The Government of Québec, in conjunction with the other provinces, propose a strategy for major investments in technological and medical infrastructures, information systems and fixed assets;
- Considerable resources be added to the level of primary care in order to adapt these services;
- Contributions be established over a five-year transition period, recognizing that it is the responsibility of the Government of Québec to establish priorities and administer the funds.

RESOURCE ALLOCATION

R-22 We recommend that

- The MSSS and the Conseil du trésor review resource allocation methods in accordance with the objectives pursued in terms of organization of services, productivity incentives and targeted results;
- They use a similar approach to adapt compensation and payment mechanisms for providers.

REVIEWING THE BASKET OF SERVICES

R-23 We recommend that

- The government adopt, by law, a highly credible mechanism, the goal of which would be to evaluate and continuously review the basket of insured services, new medical technologies and new drugs;
- It be composed of scientific and medical experts, ethicists and citizens who are recognized for their humanism.

MONITORING FACTORS IN THE GROWTH OF COSTS

R-24 We recommend that

- The MSSS and the Conseil du trésor adopt a specific monitoring plan for each of the main factors of growth in health and social services expenditures;
- They report annually on their findings and the action that has been taken.

The main growth factors are:

- Increasing poverty;
- Accelerated population ageing;
- The cost of drugs;
- The cost of medical technologies;
- The overall payment mechanism for managers, physicians and unionized workers;
- Budgeting and operating "in silos";
- The rigidity of collective agreements and absenteeism;
- Compartmentalization of professions and tasks.

EFFECTIVENESS AND EFFICIENCY

R-25 We recommend that

The MSSS implement a priority action program aimed at achieving effectiveness and efficiency in the overall management of the network.

This action program should include the following:

Various recommendations already dealt with in the report:

- Implementation of smart card and computerized, shareable health record;
- Review of budgeting methods;
- Establishment of unified boards of directors;
- Accountability, accounting reports and performance contracts;

- Principle of subsidiarity in resource utilization;
- Implementation of an Info-Social system;
- Restructuring of support services;

Other cost-cutting measures such as:

- Greater visibility of health and social services costs;
- Centralization of purchases;
- Emergency room triage;
- Membership in the Canadian Institute for Health Information (CIHI)

A PARTNERSHIP POLICY FRAMEWORK

R-26 We recommend that

- The Government of Québec adopt a policy framework of partnership with the private sector and third sector;
- This policy speed up the investments necessary to adapt services to the new realities and improve accessibility of services for everyone, regardless of their income.

The following are sectors that have considerable investment needs and/or where the supply of services must be adapted rapidly to change:

- Information technologies;
- Optimizing the use of drugs;
- Research and development;
- Long-term care services;
- Individual and community services provided by the third sector.

A NATIONAL INVESTMENT CORVÉE

R-27 In order to upgrade the technological capacity and real estate holdings of the network, we recommend that

The Government of Québec launch a national investment corvée.

Four priority areas:

- Maintaining real estate assets;
- Information and communication technologies;
- Support equipment in institutions that offer hostel services (laundry, kitchen, cafeteria)
- Medical equipment.

TAXATION AT THE SERVICE OF TECHNOLOGY

R-28 In order to fund the rapid acquisition of high-tech equipment, we recommend that

> The creation of a large foundation and the stimulation of existing hospital foundations in order to mobilize resources in support of a corvée to acquire medical technologies by means of tax measures.

LOSS-OF-AUTONOMY INSURANCE PLAN

R-29 We recommend that

> An insurance plan on a capitalization basis be created to cover loss of autonomy.

A capitalized plan could have the following characteristics:

- Funded through a mandatory contribution based on personal income from any source;
- Capitalized at a rate so as to decrease the foreseeable financial impact linked to the cost of these services for the younger generation;
- The accumulated funds for the benefit of contributors to the plan would be protected through means of solid legal mechanisms;
- The range of insured services would be defined and oriented towards support for home care while at the same time covering various types of residential services;

- The operational management would be consistent with the Commission's recommendations regarding the *Family Medicine Groups* and networks of integrated services;
- The plan would cover long-term losses of autonomy (longer than 6 months or irreversible);
- Home care could be offered through benefits in kind or monetary benefits;
- Monetary benefits for home care would be determined, as needed, through the care plan. They would be non-taxable in the hands of the beneficiary or recognized informal caregivers, depending on levels and circumstances to be determined;
- The needs of persons will be evaluated according to a single scale in all CLSCs so as to ensure that eligibility is equitable;
- The management of the plan should give true power and responsibility to teams to purchase the most appropriate services at the best cost;
- Such a plan would insure all persons who have lost their autonomy in the long term or only seniors;
- Current budgets for home care and residential care and the resources from the new plan should be integrated;
- Management must promote the use of the most appropriate resources.

A STRATEGY FOR FINANCING PRIORITY NEEDS

R-30 We recommend that

> **The government adopt a strategy aimed at ensuring the financing of priority needs and the transition to a new, more effective organization of services.**

The Commission considers that the priority needs to be financed are:

- Restructuring of the front line;
- Home care and long-term care for persons who have lost their autonomy;
- Services for young people with adjustment problems;
- Upgrading the network's technological capacity and real estate.

GOVERNANCE:

CLARIFYING ROLES AND STRENGTHENING THE ACCOUNTABILITY OF SENIOR ADMINISTRATORS

6 recommendations, 13 proposals

NATIONAL GOVERNANCE

R-31 We recommend that

- The government define precisely the role of national governance in a way that meets the contemporary political challenges of health and welfare and that frames the overall management of services on the basis of the principles advocated by the Commission;
- The change in the role of the MSSS emphasize the functions aimed at developing strategic directions, health and social policies and the evaluation of results;
- The government set up a task force with the mandate to provide advice on various options, particularly the renewal of the MSSS, the creation of a national agency, and any proposal aimed at making national governance more suitable to the challenges of the future;
- This task force be comprised of top public administrators, experienced managers from the business world, health professionals, and citizens.

REGIONAL GOVERNANCE

R-32 We recommend that

- The MSSS confirm the necessity of regional boards that are responsible and accountable to it,
- The boards have considerable manoeuvring room and autonomy to implement departmental orientations in health and social services, organize services in the region and allocate resources.

This recommendation is supported by 7 proposals:

P-47 We propose that

The board of directors of regional boards be composed of 14 members appointed by the government, including:

- 4 persons recognized for their management skills and residing in different parts of the regional territory;
- 3 persons recognized for their management skills from the health and social services sector;
- 1 member of the National Assembly, but not a minister, chosen by National Assembly members of the region concerned according to a mechanism to be agreed on;
- 1 person from the community sector;
- 1 person from the education sector;
- 1 person from the union sector;
- the president of the Regional Medical Commission;
- the president of the Regional Nursing Commission;
- the executive director.

P-48 To consult and inform the population, we propose that

The board of directors of regional boards be responsible for creating a Citizens' Forum to give advice on the region's health and welfare issues.

P-49 To improve the organization of care, we propose that

The board of directors of each regional board set up a Regional Nursing Commission to give advice on the organization and integration of care in the territory.

P-50 To strengthen managerial operations, we propose that

The regional boards adopt the Commission's guiding principles on governance, that is, population-based responsibility, territoriality, accountability, primacy of results, subsidiarity, importance of management, and citizens' participation.

P-51 We propose that

The responsibilities and accountability of the regional board to the central authority be expressed concretely in a three-year performance contract that is negotiated between the two parties and evaluated and adjusted annually.

P-52 We propose that

The regional board have the power to supervise and investigate the following cases:

- An institution that does not comply with the law and its regulations;
- An institution that tolerates a situation which could endanger the health and welfare of the persons served;
- An institution that is strongly suspected of embezzlement or of making serious management mistakes.

P-53 We propose that

The executive director be appointed by his board of directors subject to approval by the Minister.

R-33 We recommend that

Primary care institutions be brought under one single authority in a given territory. This should include, within a unified board of directors, one or several CLSCs, one or several CHSLDs and, if applicable, the local hospital.

This recommendation is supported by 3 proposals:

P-54 We propose that

A unified board should include only one council of physicians, dentists and pharmacists (CMDP), one council of nurses (CII) and one multidisciplinary council (CM).

P-55 We propose that

The unified board of directors be responsible for setting up a mechanism whereby all public and private health and social services professionals in its territory can advise it on the organization of services.

P-56 We propose that

Institutions and regional boards recognize the vital contribution of community organizations, social economy enterprises and cooperatives in the health and social services sector.

R-34 To increase administrative skills, ensure that health and social professionals continue to work in the community and that citizens continue to participate, we recommend that

Some members of the board of directors of local institutions be elected while others be appointed.

FOSTER THE HIERARCHICAL CONFIGURATION OF SPECIALIZED SERVICES ON A REGIONAL AND NATIONAL SCALE

R-35 We recommend that

- Members of the boards of directors of regional-level specialized institutions be appointed on the basis of the following factors:
  - ❑ Links with primary care institutions and representation of the region;
  - ❑ Skills in governance;
  - ❑ Specific professional expertise;
- Members of the board of directors of institutions with national or supranational mandates be appointed on the basis of the following factors:
  - ❑ Links with the regional boards served;
  - ❑ Links with primary and secondary care services institutions;
  - ❑ Skills in governance;
  - ❑ Links with the university: teaching and research (if applicable);
  - ❑ Specific professional expertise.

INCREASE ACCOUNTABILITY AND EVALUATE PERFORMANCE

R-36 We recommend that

Three-year performance contracts be negotiated between the institutions and the regional board on the basis of shared responsibility and clear accountability for results to be achieved, and be assessed annually.

This recommendation is supported by 3 proposals:

P-57 We propose that

The boards of directors of institutions adopt the Commission's guiding principles on governance.

P-58 We propose that

The boards of directors of institutions set up a performance evaluation committee.

P-59 We propose that

The boards of directors of institutions adopt effective and diversified means to consult and inform the population.

The Commission d'étude sur les services de santé et les services sociaux (Commission of study on health and social services) was created on June 15, 2000. It was given the mandate to hold a public discussion on the issues facing the health and social services system and to propose solutions for the future. To do this, it gathered the points of view of the population, health network partners, representative organizations and experts, mainly on the two themes relating to its mandate: the financing and organization of services.

To carry out this mandate, the Commission consulted 6,000 citizens from all of Québec's regions, 200 national groups, approximately 30 Québec, Canadian and international experts, and more than 1,000 strategic actors from the health and social services network. In addition to these activities, 5,000 Québeckers responded to a survey conducted by the Commission and 500 others to a vox populi presented on the Commission's Internet site.

Throughout the Commission's mandate, the energy of Québeckers was channelled into searching for realistic and effective solutions. This report presents the recommendations and proposals that emerged from this vast consultation.

Québec
Commission d'étude sur
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